Australian
Medical Council Limited

Submission to

House of Representatives
Standing Committee on Health and Ageing

Inquiry into Registration Processes and Support for Overseas Trained Doctors

SUBMISSION SUMMARY

The Australian Medical Council (AMC) is a national standards body, currently appointed under the Health Practitioner Regulation National Law Act 2009 as the external accreditation authority for medicine. In this capacity it is responsible for the accreditation of basic medical education (medical courses) and specialist medical training leading to registration. It also conducts the assessment of non-specialist International Medical Graduates (IMGs) leading to general registration and facilitates the assessment of overseas trained specialists by the relevant Specialist Medical Colleges.

In this submission, the AMC addresses:

- The development of the assessment pathways for IMGs leading to registration
- The 2007 Council of Australian Governments IMG assessment initiative and the development of consistent national approaches to assessment and registration of IMGs
- The current assessment pathways for IMGs
- The assessment outcomes for each of the current pathways, including statistics for:
    - The Competent Authority pathway for fast-tracking non-specialist IMGs
    - The current AMC MCQ and clinical examinations including performance statistics by country of training
    - The initial data from the new Workplace-based Assessment pathway that is still under development
    - The outcome of the AMC/Specialist College assessment pathway with statistics by specialty

- The submission explores some of the factors that impact on assessment outcomes and need to be considered in relation to any new assessment initiatives. This includes:
    - The diversity of training and experience of IMGs
    - The age profile of candidates
    - The specific characteristics of specialist training and practice that impact on assessment and registration
    - The scale of the IMG issue
    - The tension between workforce and standards/safety considerations
    - The diversity of roles and responsibilities of IMGs within the Australian health care system and the risk matrix model of assessment
    - The assessment versus monitoring trade-off

- The submission explores the challenges, issues and impediments to the recognition and registration of IMGs, including:
    - Access to assessment for IMGs seeking non-specialist registration
    - Access to information and compliance issues
    - Procedural consistency in specialist assessment and registration
        - The role of the Joint Standing Committee of Overseas Trained Specialists (JSCOTS)
        - Administrative processing issues
        - Accountability for specialist assessment in the new national registration system

- Bridging programs
- Orientation
- Rollout of the Standards Pathway (Workplace-based Assessment) pathway and its implications for the medical workforce
- The supervision challenge
- Recognition of prior training, assessment and experience leading to specialist registration.

The AMC considers that the reforms initiated by COAG in 2007 and the establishment of the National Registration and Accreditation Scheme in 2010 represent the most important contributions to developing genuinely consistent national policies and procedures for the recognition and registration of International Medical Graduates. The AMC looks forward to working with the Medical Board of Australia, the Specialist Medical Colleges and the other stakeholders in progressing these initiatives.

INTRODUCTION

Currently, overseas trained doctors make up a substantial portion of the medical workforce in Australia, estimated variously in the order of some 25% of the total workforce but substantially higher in regional and remote communities[1]. Despite the increase in medical schools and expected output of locally trained medical graduates, it is evident that Australia will continue to rely on the contribution of overseas trained medical practitioners for some time to come.

The issues relating to the registration of overseas trained doctors currently before the House of Representatives Standing Committee on Health and Ageing are not new. This area has been extensively reviewed since assessment processes for the purposes of registration were implemented on a national basis in 1978. Commencing in 1982, reviews have been conducted at State and Federal level by Government Departments, independent inquiries, statutory commissions, and independent consultants. The issue has seen legal challenges to assessment and registration processes before the Human Rights and Equal Opportunity Commission, the full bench of the Federal Court, and the United Nations Committee on the Elimination of Racial Discrimination. In addition, the specialist assessment process has been the subject of a comprehensive investigation by the Australian Competition and Consumer Commission (ACCC).

Despite the volumes of material that have been produced as a result of these inquiries and reviews, it is evident that there is still some confusion about this issue and the challenges it presents. It is clear from any reasonable review of the facts that considerable progress has been made in standardising assessment and registration procedures in Australia for overseas trained doctors. The most significant developments in recent years have arisen from the COAG IMG assessment initiative launched in 2007 and the implementation of the National Registration and Accreditation Scheme in 2010. It is to be hoped that with the new national registration framework and consistent national policies on assessment and registration, further progress can be made in facilitating the entry of qualified, competent and safe overseas trained medical practitioners into the Australian medical workforce.

TERMINOLOGY

Over the years considerable confusion has arisen regarding the classification of overseas trained doctors because of the different terminology used. The most common term – Overseas Trained Doctors (OTDs) was considered in the mid-1990's to imply some value judgement and was gradually replaced by the term International Medical Graduates (IMGs). This classification is now the international standard terminology and is reflected in the inventory of international assessment systems prepared by the International Association of Medical Regulatory Authorities (IAMRA)[2] It is the terminology that is used in all Australian Medical Council (AMC) publications. The term Overseas Trained Specialists (OTS) is still in use but is being replaced by the term Specialist IMG.

[1] In 2005/06 International Medical Graduates (IMGs) were estimated to represent some 25% of the total medical workforce, but 35% of the workforce in outer metropolitan and rural areas. The AMC understands that in some rural centres the total medical workforce consists of IMGs

[2] SEE; http://www.iamra.com IAMRA Assessment Resource

BACKGROUND TO THE ASSESSMENT AND REGISTRATION OF INTERNATIONAL MEDICAL GRADUATES IN AUSTRALIA

The registration of medical practitioners, under the federal system of government in Australia, had been a responsibility of the States and Territories until the implementation of the National Registration and Accreditation Scheme in July 2010. Each State and Territory had its own legislation regulating the practice of medicine and its own practices and procedures for the assessment and registration of medical practitioners. In 1978, Commonwealth and State Health Ministers agreed to establish a single national assessment process for overseas trained doctors seeking general (non-specialist) registration in Australia, based on the final qualifying examinations of the University of Melbourne. At that time the process was limited to overseas trained doctors who were Australian citizens (or who had resident status or were migrating to Australia on a permanent basis). There was no separate provision for overseas trained specialists and the process was not open to temporary resident doctors, such as those working in area of need positions.

It is worth noting that at that time there were very few temporary resident (area of need) positions in Australia, due in part to the fact that medical graduates from the United Kingdom and Ireland were recognised under the State and Territory Medical Acts and were eligible to apply for general registration in Australia. These appear to have made up the bulk of the "temporary" medical workforce until 1991.

By 1989 it was recognised that the then assessment process for general registration was not appropriate for the assessment of overseas trained specialists. In October 1990 the Medical Board of New South Wales pioneered a process whereby an overseas trained specialist would be assessed by the relevant Specialist Medical College in Australia against the standard required for an Australian trained specialist in the same field of specialty practice. If they were assessed as "equivalent" they could be granted registration limited to their field of specialty without having to present for the national examination for general registration. In 1993 the specialist assessment pathway was implemented on a national basis, following agreement of the State and Territory Medical Boards.

In 1991, the Australian Health Ministers Conference, in anticipation of the implementation of the Mutual Recognition Scheme, agreed to "harmonise" the various State and Territory Medical (Practitioners) Acts, which included removal of the automatic recognition of UK and Irish medical qualifications. This appears to have been a political decision and not based on any evidence relating to the standards or quality of medical training in the UK and Ireland. Indeed, up to this time, Australian medical schools had been subject to accreditation by the General Medical Council of the UK for the purposes of registration for postgraduate training in the UK. This decision was to have far reaching consequences on the medical workforce in Australia.

Although agreed national processes were in place to deal with the assessment and registration of overseas trained doctors seeking to enter the medical workforce on a permanent basis, individual States retained their own discretionary powers within their Medical (Practitioners) Acts to register IMGs who did not meet the national standards under "public interest" categories or for designated area of need positions. The medical workforce policies and assessment processes that were applied under these provisions varied considerably between the states. Various attempts to develop nationally consistent policies to deal with the "area of need" issue throughout the 1990's lapsed due to concerns at the state level about the negative potential impact

on the available medical workforce.

In 2000 an initiative sponsored by the Commonwealth Department of Health and Ageing brought together the key stakeholders to develop a national policy and procedures for the assessment and registration of overseas trained specialists for area of need positions. The model was based on an assessment against a defined description of the levels of clinical responsibility, required levels of skills and level of supervision for a specific area of need position. Individual applicants would be assessed against the requirements of the area of need position, rather than against the standards required for an Australian trained specialist in the relevant specialty field. After extensive negotiation and consultation with the relevant stakeholders, the new area of need specialist assessment procedure was signed off by all Medical Boards, Specialist Medical Colleges and the State Health Authorities in July 2002.

Unfortunately, lack of compliance with the agreed processes would continue until the high profile case of an overseas trained specialist would highlight the lack of consistency in application of consistent national approaches to the assessment and registration of overseas trained specialists. In 2005, as the news of the Patel case in Bundaberg hit the media, the Commonwealth Department of Health and Ageing was conducting a workshop of key stakeholders to identify and develop consistent national procedures for the assessment and registration of overseas trained medical practitioners. In 2006 this initiative was taken up by the Council of Australian Governments (COAG) as part of the regulatory reform agenda and the development of the National Registration and Accreditation Scheme. The COAG International Medical Graduate (IMG) Assessment Initiative, which began to be rolled out in 2007, established the assessment and registration processes that now apply to overseas trained medical practitioners seeking to enter the medical workforce in Australia.

COAG IMG ASSESSMENT INITIATIVE

The proposed COAG model for nationally consistent assessment processes for International Medical Graduates (IMGs) included the following elements:

- Full implementation of primary source verification of all medical qualifications
- Compliance with nationally agreed English language proficiency standards
- Implementation of a model for fast-tracking non-specialist overseas trained doctors based on approved prior assessment or recognised accredited training – The Competent Authority Model.
- Implementation of a mandatory screening examination for all non-specialist overseas trained doctors (who were not qualified for the Competent Authority pathway) to be followed by either:
    - The existing AMC clinical examination; OR
    - A new workplace-based assessment pathway (where the clinical assessment was undertaken in the workplace setting)
- Development of an accredited pre-employment structured clinical interview
- Development of standardised position description forms
- Development of standardised supervision guidelines
- Development of guidelines for orientation programs
- Establishment of a joint AMC/Specialist College standing committee on the assessment of overseas trained specialists, to include jurisdictional membership, to ensure consistency of application of assessment processes by all parties.

The development of these initiatives was subject to oversight by a COAG Implementation Committee, chaired by the Commonwealth, which reported to the Australian Health Ministers Advisory Council (AHMAC) through the Health Workforce Principal Committee (HWPC). An extract of the Final Report of the Implementation Committee is at **APPENDIX A.**

CURRENT ASSESSMENT PATHWAYS FOR OVERSEAS TRAINED DOCTORS

As a result of the COAG IMG assessment initiative, there are currently four main pathways for overseas trained doctors to be assessed for the purposes of registration in Australia are set out in TABLE 1.

TABLE 1: ASSESSMENT PATHWAYS FOR OVERSEAS TRAINED DOCTORS AS AT 2011

1. **Competent Authority Pathway** for international medical graduates seeking non-specialist registration who have completed training/or assessment through an AMC designated and approved authority. Applicants in this pathway would be granted advanced standing towards the AMC Certificate. These overseas trained doctors would be required to complete further workplace-based assessment of performance in order to qualify for the AMC Certificate and be eligible to apply for general registration, but will not be required to sit and pass the AMC MCQ and clinical examinations.

2. **Standard Pathway (AMC MCQ and Clinical Examination)** for international medical graduates seeking non-specialist registration in Australia who are not registered and working in clinical positions in Australia. Overseas trained doctors must present for and pass the MCQ examination before they can proceed to the clinical examination.

3. **Standard Pathway (Workplace-based Assessment Pathway)** for international medical graduates who do not qualify under the Competent Authority Pathway, and are applying for non-specialist area of need or similar positions. Under this pathway IMGs would complete the AMC MCQ examinations (or the offshore MCQ examinations), a pre-employment structured clinical interview (if required by the Medical Board of Australia) and an AMC accredited workplace-based assessment of their clinical skills. They would not be required to complete the AMC clinical examination.

4. **Specialist Pathway** for overseas trained specialists who are assessed through the AMC/Specialist College Pathway. There are three categories for assessment of overseas trained specialists:

    I. **Specialist seeking registration for independent practice**. These overseas trained specialists are assessed against the standards of the relevant Specialist Medical College for Australian trained specialists in the same field of specialty practice.
    II. **Specialist – Area of Need Positions**. These overseas trained specialists are assessed against the position description of the specific area of need position. [Note: These may be assessed as suitable to take up a specific area of need position under limited registration, even though they may not meet the requirements as "substantially comparable" to an Australian trained specialist (suitable for independent practice).]
    III. **Specialist-in-Training**. These are overseas trained doctors seeking to undertake limited specialist training in Australia in order to complete their specialty qualifications. They are assessed by the relevant Specialist Medical Colleges against a proposed training program.

PRIMARY SOURCE VERIFICATION

Primary source verification was implemented in Australia on a national basis from January 2006. It involves the medical qualifications documents of all IMGs being electronically scanned and sent to the Educational Commission for Foreign Medical Graduates of the United States (ECFMG) for verification. The ECFMG forwards the documents on to the original issuing authorities for confirmation that they were issued to the IMG concerned. The ECFMG maintain an annually updated list of designated officials who are authorised to verify qualifications.

In 2010 the AMC received a total of 6,014 applications for primary source verification. Some 5,642 sets of qualifications were sent to the ECFMG in 2010 and 2,862 verification were received. [The numbers verified are not a subset of the verifications ordered in 2010, as some qualifications that were verified in 2010 may have been submitted in previous years.]

COMPETENT AUTHORITY PATHWAY (NON-SPECIALIST)

The Competent Authority (CA) assessment pathway was implemented in 2007 as part of the COAG IMG assessment initiative. The model was originally developed jointly by the Queensland Department of Health and the AMC.

The CA model recognises that there are a number of established international screening examinations for the purposes of medical licensure that represent a "competent" assessment of applied medical knowledge and basic clinical skills to a standard consistent with that of the AMC examination for non-specialist registration. A total of four examination systems and two accreditation systems were reviewed and approved by the AMC as Competent Authorities for the purposes of this assessment model. These are:

- The PLAB Examination of the United Kingdom
- The Medical Council of Canada Licensing Examination
- The USMLE of the United States
- The NZREX of New Zealand
- GMC accredited Medical Schools in the United Kingdom
- Medical Schools in Ireland accredited by the Medical Council of Ireland.

In order to be eligible for assessment through the CA pathway and IMG must:

- Possess a primary medical degree from a medical school listed in the International Medical Education Directory OR
  from a medical school in the UK accredited by the GMC or in Ireland accredited by the Medical Council of Ireland
- Have passed all components of the prescribed licensing examination or accredited medical course
- Have completed the required Foundation Year/ residency/ rotations or not less than 12 months post-examination practice in a designated CA country.

Since the CA pathway does not require further formal assessment of an applicant's medical knowledge and clinical skills, it was decided, from a safety and standards perspective, that an IMG following the CA pathway should undergo assessment of

his/her ***clinical performance within the Australian healthcare context*** before general registration is granted. If the applicant meets the eligibility requirements, he or she will be awarded Advanced Standing towards the AMC Certificate and will be eligible to apply for limited registration to complete up to twelve months performance assessment in a designated position prior to being eligible to receive the AMC Certificate.

Since the CA model was implemented in July 2007, over 4,800 applications for CA assessment have been processed by the AMC. A total of 3,281 certificates of Advanced Standing have been issued, allowing the applicants to apply for limited registration and to commence work in the Australian healthcare system. As at end of 2010 some 1,990 applicants (from 56 countries of training) have completed the performance assessment component and qualified for the AMC Certificate leading to general registration. A breakdown of applications for assessment through the CA pathway by country of training is set out at **APPENDIX B**.

During the calendar year 2010 the AMC received a total of 1,281 applications for CA pathway assessment. In the same period a total of 1,153 applicants were granted Advanced Standing and some 494 completed the performance assessment and qualified for the AMC Certificate. A breakdown of CA applications for the calendar year 2010 by country of training is set out at **APPENDIX C**.

[It is important to note that the data for Advanced Standing and AMC Certificates issued are not subsets of the number of applications received in the reporting period. Some of the applicants will have applied in a previous years but have completed or been approved for Advanced Standing in 2010.]

The CA assessment pathway does not rely on mutual recognition, bilateral agreements with other countries or reciprocity of recognition. It is based on the recognition of prior assessment through a designated screening examination or formally accredited training program for the purposes of licensure/registration.

The informal feedback received by the AMC indicates that the Competent Authority pathway has been well received and generally considered a success. The AMC understands that the Commonwealth Department of Health and Ageing has more specific formal feedback of the implementation of the Competent Authority model.

STANDARD PATHWAY (AMC EXAMINATIONS)

The AMC examination for non-specialist registration consists of two sequential components:

- A computer-administered multiple choice question (MCQ) examination of 300 items (240 scored)[3] available in secure computer sites both in Australia and offshore
- A multi-station 16 component test (OSCE format) of clinical skills currently conducted in clinical facilities (teaching hospitals) in Australia only.

There has been a steady increase in the demand for the AMC examination since the national assessment was implemented in 1978 for overseas trained doctors seeking non-specialist registration in Australia. A breakdown of the numbers of candidates

[3] This examination format will be replaced from 2011 with a new 150 item (120 scored) computer-adaptive test format. This represents the state of the art for screening examinations.

presenting for the MCQ and the clinical examinations by financial years in set out at **APPENDIX D.**

AMC MCQ Examination

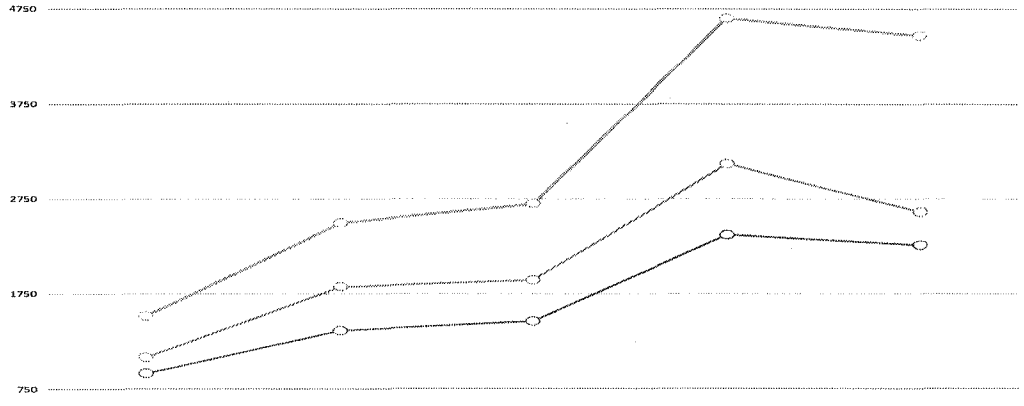
There has been a steady increase in the demand for AMC MCQ examinations over the last five years, rising from a total of 1,509 in 2005/06 to 4,466 in 2009/10. There was a sharp increase after July 2008 with the decision to make the AMC MCQ examination mandatory for non-specialist limited registration as part of the COAG IMG assessment initiative.

TABLE 2 below indicates the pattern of MCQ examinations over the last five years:

A breakdown of all candidates who have presented for MCQ examination by country of training and numbers of attempts is set out at **APPENDIX E**. The pattern of passing shows that there is a significant fall-off in the pass rates after two attempts at the MCQ examination with 66.77% of candidates who pass doing so at their first attempt, 19.69% at their second attempt, 7.2% at their third attempt and 6.2% at their fourth or subsequent attempt. The data for 2010, which is consistent with previous years, shows that the majority of candidates who will pass the MCQ examination (84.54%) will do so within two attempts and that the pass rates flatten out after two attempts **(APPENDIX F).**

TABLE 2: MCQ Examinations for Financial Year: 2005/06 – 2009/10 (All candidates)

	2005/06	2006/07	2007/08	2008/09	2009/10
Total Passed	908	1355	1454	2366	2258
New Candidates	1075	1819	1888	3112	2610
Total Examined	1509	2494	2695	4646	4466



AMC Clinical Examination

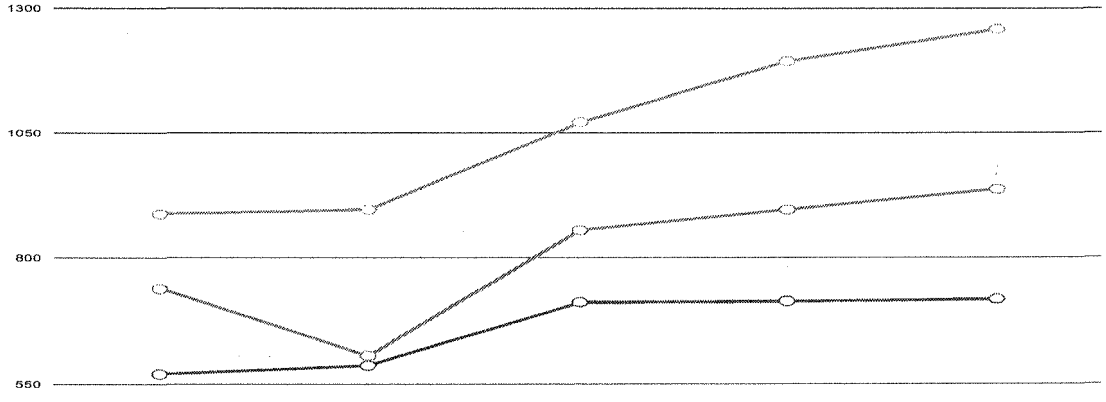
The demand for clinical examination places has also increased over the last five years, in part due to the need to accommodate the flow-on demand from the COAG IMG assessment initiative decision to mandate the MCQ examination as a front end

screening test for limited registration. The delivery of clinical examinations has increased from a total of 887 in 2005/06 to 1,258 in 2009/10. In the calendar year 2010 the number of clinical examinations peaked at 1,596. The capacity to deliver clinical examinations is limited by the availability of suitable clinical examination venues, numbers of examiners and role playing and real patients. At present the AMC is conducting clinical examinations every two and a half weeks throughout the year.

TABLE 3 indicates the pattern of clinical examinations over the last five years. A breakdown of all candidates who have presented for the clinical examinations by country of training and numbers of attempts is set out at **APPENDIX G**. As with the MCQ examinations, the pass rates fall away sharply after two attempts, with 67.73% of the total who pass, passing at their first attempt, 22.43% at their second attempt, 7.02% at their third and 3.54% at their fourth or subsequent attempt. The pass rate by attempts is even more marked at the clinical examinations with 93.37% of those who passed in the calendar year 2010 passing within two attempts (**APPENDIX H**). This may have implications for the renewal of registration of practitioners with limited registration and multiple repeat failures at the AMC clinical examinations.

TABLE 3: Clinical Examinations for Financial Year: 2005/06 – 2009/10 (All Candidates)

	2005/06	2006/07	2007/08	2008/09	2009/10
Total Passed	569	586	711	713	717
New Candidates	738	605	854	895	936
Total Examined	887	895	1071	1194	1258



Standard Pathway (Workplace-based Assessment)

Although this pathway was included in the original 2007 COAG IMG Assessment Initiative proposals and report to AHMAC by the COAG Implementation Committee, it was not endorsed or signed off by the jurisdictions. As a result, the rollout of the Workplace-based Assessment pathway has been delayed.

As at January 2011 there are four authorities/consortia accredited by the AMC to conduct workplace-based assessment for overseas trained doctors seeking non-

specialist registration, including:

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

Hunter New England Area Health Service

In June 2010, 27 candidates commenced the accredited Standard Pathway (workplace-based assessment) at Hunter New England Area Health Service (HNEAHS), the first of the assessment programs to be approved. In December 2011 the results of the first cohort of candidates were reviewed by the AMC and the full cohort was confirmed to have passed and qualified for the award of the AMC Certificate.

TABLE 4 below shows the breakdown of WBA candidates by country of training.

TABLE 4: Hunter-New England Area Health Service Workplace-based Assessment - Outcome

Country of Training	Candidate Count
BANGLADESH	4
CHINA	2
EGYPT	1
INDIA	11
MYANMAR	1
PAKISTAN	3
PHILIPPINES	2
SOUTH AFRICA	2
SUDAN	1
Total	**27**

A second cohort of 24 candidates is due to commence the workplace-based assessment program at John Hunter Hospital (HNEAHS) in February 2011 and another cohort of 30 candidates to commence in June 2011.

Rural and Outer Metropolitan United Alliance:

When fully established the workplace-based assessment program of the Rural and Remote Metropolitan United Alliance (ROMUA), located in Central and Northern Victoria is expected to have a total potential capacity for up to 250 candidates if all positions in the Alliance hospitals were utilised. The AMC has conducted two assessor training workshops for assessors at Goulburn Valley Health for the ROMUA program. Currently, ROMUA is conducting a trial of the assessment program to test its systems.

Launceston General Hospital:

Launceston General Hospital commenced the workplace-based assessment program in January 2011 with six candidates enrolled in the program with a further two applications pending verification by the AMC.

Western Australia Health:

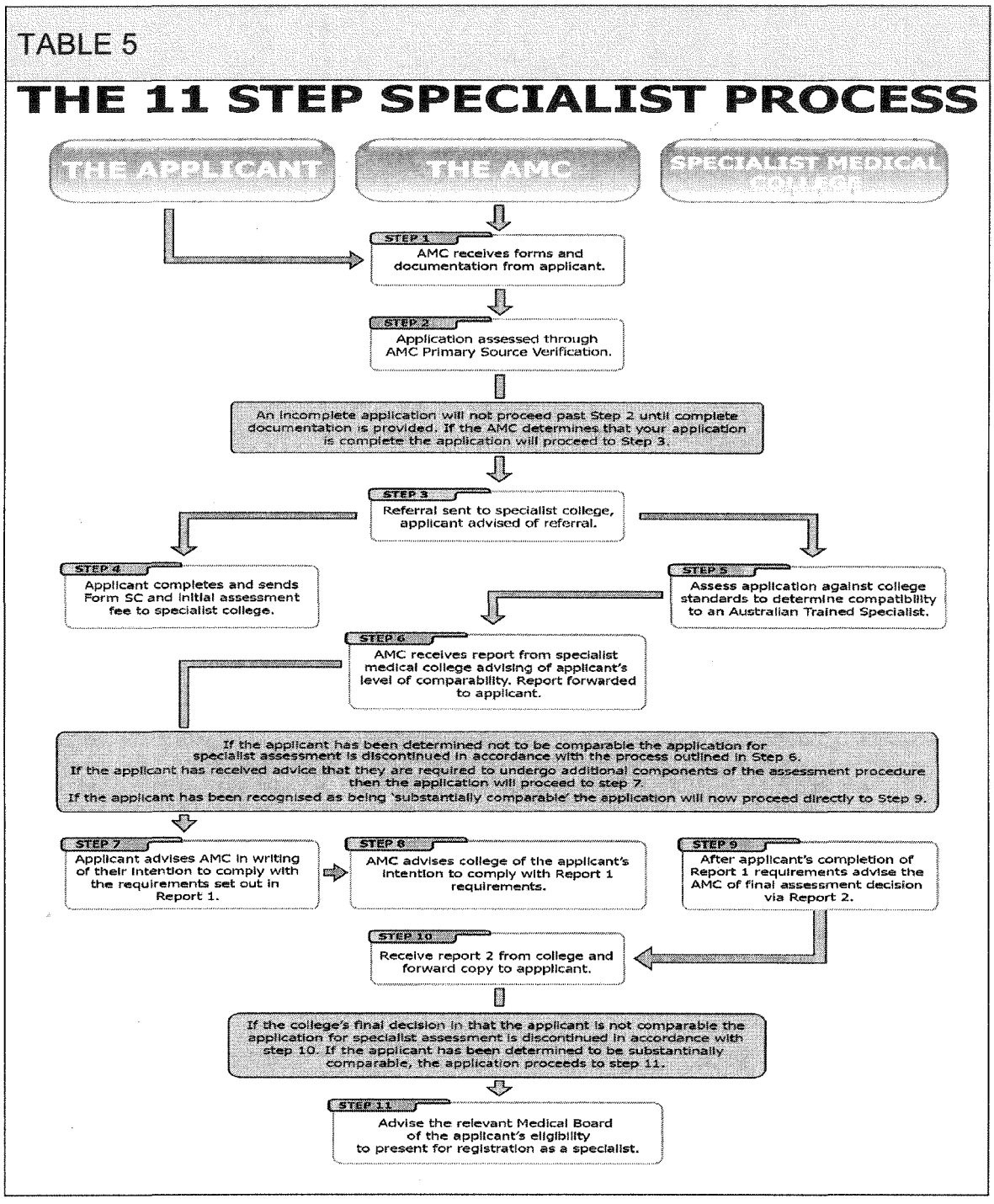
The AMC has granted accreditation for a workplace-based assessment program to a Western Australian Alliance consisting of the following representing the key stakeholders: the Postgraduate Medical Council of WA, Directors of Postgraduate Medical Education, Rural Clinical School, WAGPET, Rural Clinical School WA, WA GP Network, Rural Health West, RACGP, WA Country Health Service, Medical Workforce, Dept Health WA.

The Western Australian Alliance commenced their workplace-based assessment (WBA) program at Bunbury Hospital in August 2010 with four candidates and are planning to commence with a cohort of 12 candidates in January 2011. As a result of the strong demand for the WBA places, the Western Australian Alliance sought accreditation to bring a further two hospitals on line - Hollywood Private Hospital and Joondalup health campus.

SPECIALIST ASSESSMENT

Since 1993, the assessment of overseas trained specialists for registration to undertake unsupervised specialist practice has been undertaken by the relevant Specialist Medical Colleges with the AMC acting as a point of contact and clearing house for information. The eleven step assessment process for overseas trained specialists, as shown on the AMC website, is set out in TABLE 5 below.

TABLE 5



In the calendar year 2010 the AMC processed some 1,533 applications for specialist assessment, including 655 new applications for assessment. In this period 293 overseas trained specialists were assessed as "Partially Comparable" (requiring further training and assessment) and 408 were assessed as "Substantially Comparable" and eligible to apply for registration to undertake independent specialist practice.

A breakdown of the applications processed by specialty is set out at **APPENDIX I.**

DIMENSIONS OF THE OVERSEAS TRAINED DOCTORS ISSUE

The challenges and issues presented by the assessment and registration of overseas trained medical practitioners are not new nor are they unique to Australia. In order to effectively deal with the challenges presented by the recognition of overseas medical qualifications in Australia it is important to first recognise the dimension of this issue and the factors that may influence the recognition and registration of overseas trained doctors in Australia. The following is a summary of a number of these factors:

DIVERSITY OF TRAINING AND EXPERIENCE

The International Medical Education Directory (IMED), the major reference source for medical training, lists 2,188 recognised medical schools in 172 countries of training. The provision of medical courses is now a substantial area of growth with countries in Asia, the Caribbean, the Middle East and South America having rates of growth in excess of 25% since 2002.

There is considerable diversity in the format, content and methodology of medical training across these courses. Equally, there are significant variations in:

- The clinical context of medical practice, including the burden of disease, levels of technology and the delivery of health services.
- Professional ethics, including non-discriminatory treatment and the rights of all patients.
- The educational context, including principles, systems and delivery of medical education.

These factors have been shown to impact on the ability of an IMG to integrate into the medical workforce.

The Educational Commission for Foreign Medical Graduates of the United States (ECFMG) estimates that some two thirds of countries with medical schools have some form of quality assurance system or process of accreditation. However, these systems for quality assurance vary significantly in their processes, transparency, accountability and consequences of assessment. [4] A number of US state legislatures have responded to concerns about the standards of some international medical schools that they have now developed lists of international medical schools that are no longer acceptable for licensure.[5] On 21 September 2010 the ECFMG announced that from 2023 international medical graduates will only be eligible to sit the USMLE examination for licensure in the US if their medical schools have been subject to an accreditation process comparable to that of the US Liaison Committee on Medical Education (LCME) or the World Federation for Medical Education (WFME).

AGE PROFILE OF CANDIDATES

The age of candidates presenting for the AMC examinations ranges from 25 years to 65+ years with a mean age range of 35-40. A number of studies of performance at the AMC examinations have shown that the age profile of candidates does affect the assessment outcome. A comprehensive Commonwealth-funded study in 1999 found that 57% of AMC clinical examination candidates under 35 years of age passed on

[4] See *Requiring Medical School Accreditation for ECFMG Certification – Moving Accreditation Forward* http://www.ecfmg.org/accreditation /index.html
[5] This now includes California, Alaska, Indiana, Alabama, Kansas and Mississippi.

their first attempt compared to 38% of candidates over 35 years of age.[6] The same report also found that IMGs who required major assistance or retraining to pass the clinical examinations were more likely to be over 35 years of age.[7]

SPECIALIST TRAINING AND PRACTICE

Overseas specialist training and experience presents an even more complex challenge for recognition and registration than basic or primary medical training. There are substantial differences in the format and content of specialist training and practice between countries. Some adopt a formal postgraduate training program administered on completion of a primary (or undergraduate) medical course. Other countries integrate specialisation into the primary (or undergraduate) training with a shorter period of postgraduate specialist training than would be considered generally appropriate in Australia or other countries with developed specialist training schemes. In other countries again, there may be no formal postgraduate specialist training as such, but relevant work experience may lead to licensure to provide "specialist" medical services.

The relevant experience of an overseas trained specialist also has a major role in the recognition of that specialist for the purposes of registration or for a specific specialist position. Experience with the AMC/Specialist College assessment pathway has shown that individual overseas trained specialists have been assessed as "substantially comparable" to an Australian trained specialist based on a combination of their training and relevant experience, where the training alone would not have been considered comparable to training in Australia in the same specialty field.

It is also important to note that the sub-specialisation that occurs in many fields of specialist medical practice means that two individuals completing the same specialty training program may present with very different skills sets or expertise after a number of years of specialisation and practice. The issue of recency of practice is also an important consideration in relation to the assessment of specialist medical practice. This is now reflected in the National Law.

Strategies for assessment or recognition that may be entirely appropriate for recent graduates or at the level of primary medical qualifications, such as the Competent Authority assessment pathway, may be less appropriate or more complex to implement at the specialty level. Given the higher risks associated with specialist medical practice, any strategies to fast-track specialists into registration will require more effective monitoring of performance if screening processes and assessment requirements are to be relaxed,

SCALE OF THE OVERSEAS TRAINED DOCTOR ISSUE

The steady increase in numbers of overseas trained doctors seeking recognition for both non-specialist and specialist registration has grown significantly over the last two decades, as evidence in the data shown in TABLE 2. In the case of overseas trained specialists, this brings with it challenges in relation to assessment processes and ensuring continuity and consistency of process. In the smaller Specialist Colleges, a turn over of staff together with a relatively small number of cases being processed can impact on the consistency of the assessment process. In the larger Specialist Colleges, the numbers of cases being assessed can strain the resources

[6] ARTD Management and Research Consultants. Research Study on Bridging Courses for Overseas Trained Doctors. Commonwealth Department of Health and Ageing. Canberra 2000 p.42
[7] ARTD p.46

available to conduct the assessment, due in part to the need to match the qualifications and area of specialisation of the candidate with a suitable qualified assessor from the College.

WORKFORCE vs. STANDARDS ISSUES

Perhaps the most unfortunate aspect of the recognition of overseas medical practitioners in Australia has been the tension between considerations of workforce supply and standards. In the last two decades, the national policy on medical workforce has swung between concerns of significant oversupply (1992), resulting in quotas on the AMC examination and points penalties on migration applications for medical practitioners, to concerns of undersupply resulting in active recruitment of overseas trained health professionals and considerations of task substitution and regulatory reform (2005). It appears that in times of perceived workforce shortage, considerations of workforce supply may take precedence over issues of standards with potentially adverse outcomes for patient safety.

In the case of overseas trained specialists in Australia, this tension between workforce and standards reached a climax with the Patel case in Queensland. Despite the fact that a process for the assessment and registration of overseas trained specialists and been developed after lengthy negotiations with all parties and sign-off by the relevant stakeholders, elements within Queensland Health opted to appoint Dr Jayant Patel to a senior position, by-passing the nationally-agreed assessment processes. This, coupled with a failure to monitor his performance and to inform the relevant regulatory authority, resulted in the now well documented adverse outcomes for the community of Bundaberg.

There is no doubt that the Patel case has had both a positive as well as a negative impact on the assessment of overseas trained doctors in Australia. In 2006 it led to the implementation on a national basis of primary source verification of medical qualifications in Australia. It also contributed to the roll out of the COAG IMG assessment initiative in 2007, including the mandatory screening of all non-specialist overseas trained doctors who were not eligible for the Competent Authority pathway through the AMC MCQ examination as a pre-requisite for limited registration. However, the negative outcome of the appointment and registration of Dr Patel has heightened concerns about errors in assessment and appears to have resulted in a more conservative and cautious approach being taken by some Specialist Colleges towards the recognition of overseas trained specialists.

It would be reasonable to expect that after the considerable publicity and cost of the Patel case, the issue of standards and public safety would no longer be secondary to workforce considerations. However, the AMC and other standards bodies noted with concern that an earlier draft of the proposed Health Practitioner Regulation National Law that underpins the new National Registration and Accreditation Scheme contained a provision for the (Health) Ministerial Council to give directions to a National Board in relation to accreditation standards (which include assessment standards), where in the opinion of the Ministerial Council, the standard will have a negative impact on the recruitment or supply of health practitioners.[8] An amendment included in the final draft of the National Law added the proviso that the Ministerial Council must first give considerations to the impact of any such direction on the quality and safety of health care.[9]

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[8] Heath Practitioner Regulation National Law Act 2009 Act No.45 of 2009 Part 2 Sub-section 11 (4) (a).
[9] Sub-section 11(4)(b)

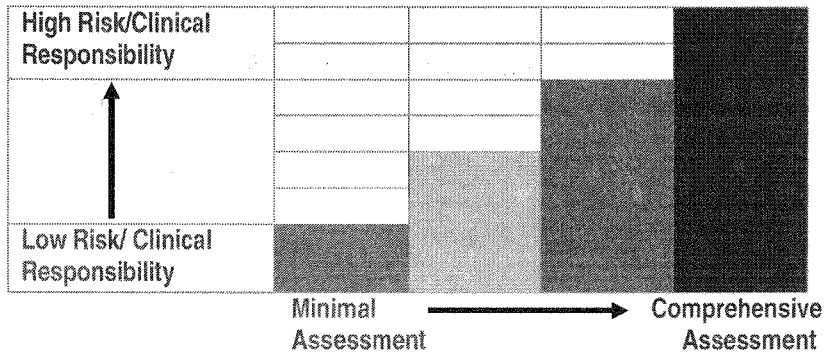
DIVERSITY OF ROLES AND RESPONSIBILITIES

In 2006, when the COAG IMG assessment initiative was being implemented it was estimated that in excess of 4,000 overseas trained doctors were being recruited to Australia each year primarily to fill unmet area of need positions. This is in addition to those overseas trained medical practitioners who were migrating to Australia and seeking to enter the medical workforce on a permanent basis.

The range of positions to which the IMGs were appointed varied considerably in relation their clinical responsibility and levels of supervision or oversight available. Positions have included relatively junior appointments in major hospitals as part of a team with limited clinical responsibility and reasonable levels of supervision. At the other end of the scale are high risk positions, such as senior posts in procedural areas or remote locations with high levels of clinical responsibility and minimal supervision.

Because of the variations in levels of risk to the community, the COAG IMG assessment initiative included a risk matrix model to guide the assessment and registration of IMGs where the levels of assessment and supervision requirements could be adjusted according to the perceived level of risk. This can be illustrated as follows:

Risk Matrix Model of Assessment



In the interests of public safety, as the level of risk increases so should the rigour of the assessment. This was reflected in the development and implementation of the Pre-employment Structured Clinical Interview (PESCI), an assessment which could be ordered by a Medical Board to determine whether an individual medical practitioner has the required skills and qualifications to work in a particular position and to determine the nature and scope of any supervision requirements or conditions on the registration. The PESCI assessment processes, under the COAG IMG assessment initiative, are subject to review and accreditation by the AMC.

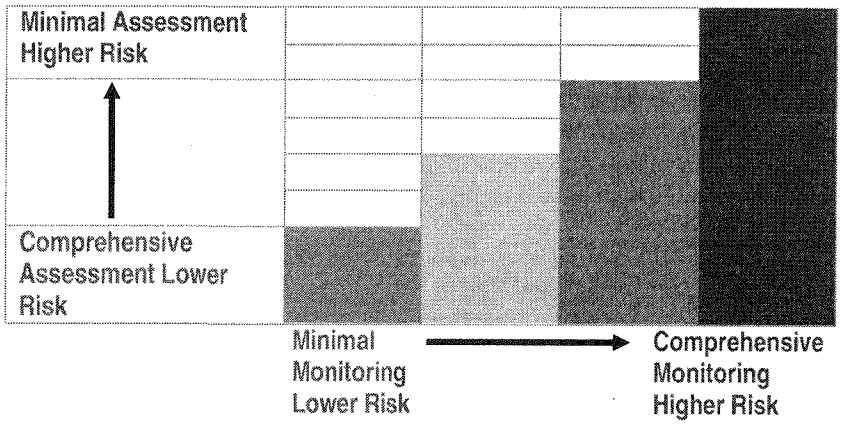
ASSESSMENT vs. MONITORING TRADE-OFF

A consistent line of argument in the debate on the recognition of overseas trained doctors in Australia has been the need to reduce the barriers to IMGs entering the medical workforce, including removing or minimising formal assessment requirements. The success of the Competent Authority pathway for non-specialist registration has shown that a more flexible approach to the assessment and registration of overseas trained doctors is possible. However, this pathway was developed on the principle that the greater the information that is available or known

about the qualifications and clinical skills of an individual overseas trained medical practitioner, the less risk there is likely to be to public safety. In the case of the Competent Authority applicants, the fact that they had already completed formally recognised licensing examinations, that were rigorous and detailed assessments of medical knowledge and clinical skills, meant that their entry to the medical workforce in Australia could be fast-tracked with confidence.

If there is to be a trade-off in assessment or fast-tracking of overseas qualified medical practitioners, especially at the specialist level where the risks are significantly higher than at the general registration level, any reduction in the rigour or completeness of the assessment needs to be balanced by a corresponding increase in the level or monitoring of clinical performance and patient outcomes. This can be *illustrated as follows:*

Assessment – Monitoring Trade-off



In the Patel case in Queensland, where the nationally agreed specialist area of need assessment process was not followed, the post-operative complications and return to theatre rates within weeks of his appointment were outside internationally acceptable standards. Even though there was no formal assessment of Patel for the appointment, careful monitoring of his performance and clinical outcomes should have identified the concerns long before the adverse events reached a critical level.

CHALLENGES, ISSUES AND IMPEDIMENTS

A number of the major challenges and impediments confronting overseas trained doctors entering the medical workforce in Australia have been identified in previous inquiries and reports dating back to the Commonwealth Fry Committee report of 1982[10]. Unfortunately there is also a certain familiarity in the various recommendations and solutions that have been presented over the years in response to these challenges. While there has been substantial progress made in a number of areas over the years, impediments to recognition still remain. In addition, the recent implementation of the new National Registration and Accreditation Scheme, that in time will no doubt address many of the inconsistencies that have been present in the registration of overseas trained doctors in Australia, has itself presented some new challenges that now need to be considered.

ASSESSMENT ACCESS ISSUES – NON-SPECIALIST REGISTRATION

Although TABLE 3 shows growth in the overall clinical examination load, it does not give a complete picture of the demand for AMC clinical examinations. A breakdown of clinical examination applications in **APPENDIX J** indicates that in the last financial year the AMC received some 6,015 applications for 1,258 available clinical examination places – a ratio of 4.8:1. This significant demand for clinical examination places can be attributed to two key factors:

The decision to implement the mandatory MCQ examination as a pre-requisite for limited registration from July 2008 without implementing the Standard Pathway (Workplace-based Assessment) has resulted in the number of candidates being eligible to present for the clinical examination increasing from approximately 900 in 2005/06 to more than 2,200 in 2009/1020. Despite the fact that the IMG assessment initiative (including the Standard Pathway Workplace-based Assessment) had been signed off by COAG, it was not signed off by all of the jurisdictions, resulting in an overload of the clinical examination capacity.

The requirement to demonstrate progress towards the general registration standard, which first appeared in the Queensland registration legislation and is now part of the National Law requirements, has resulted in a large number of failed repeat clinical examination candidates re-presenting for the clinical examinations.

The AMC has initiated three strategies to deal with the increased demand:

1. The AMC has expanded the capacity of its existing clinical examinations by running multiple concurrent clinical examinations. Up to three examination venues in different states may operate on a single day of examining. There is a finite limit that can be accommodated by this strategy due to limited numbers of examiners, role-playing patients and suitable venues.

2. The AMC is exploring options for cooperative examining utilising university medical schools facilities, staff and standardised patients (role players) at time that are not required by the universities. The initial response from the Medical Schools to this has been positive.

3. The AMC has established an Expert Advisory Panel on Assessment which includes leaders in medical education and assessment in Australia and New

[10] Fry R G. (Chairman) Report of the Committee of Inquiry into the Recognition of Overseas Qualifications in Australia. AGPS, Canberra. 1982

Zealand to explore alternative options for administering clinical examinations, including more sophisticated and resource efficient computer-delivery of clinical problem solving and clinical reasoning tests.

Increasing the front end load on the clinical examination by a factor of 140%, together with the recycling of candidates due to a clinical examination failure rate of approximately 50% and the requirement for IMGs with limited registration to demonstrate progress towards general registration, results in a demand for examination places that is beyond the capacity of the currently available examination facilities to accommodate. In the absence of endorsement of the COAG workplace-based assessment alternative, the only effective solution to this issue is to re-engineer the AMC clinical examination to utilise more resource efficient delivery of testing, such as newer formats of computer-administered tests.

ACCESS TO INFORMATION AND COMPLIANCE

Another issue that is regularly cited as a problem for IMGs is access to information about processes and format and content of examinations and other assessments. Over the last 15 years a considerable effort has been invested in developing information for IMGs intending to seek registration in Australia. A comprehensive website has been developed by the AMC that includes information about application and assessment procedures for both non-specialist and specialist assessment.

http://www.amc.org.au

In addition to numerous individual publications, handbooks and guides on non-specialist and specialist application procedures, the AMC has produced three major publications for AMC candidates to assist with preparation for the AMC MCQ and Clinical examinations. These publications are:

- **AMC Anthology of Medical Conditions – (636 pages published 2003)**

  The AMC publication *AMC Anthology of Medical Conditions* has been produced not only to assist International Medical Graduates (IMGs) to prepare for the AMC Examinations but also as an essential tool for clinical practice. The publication lists over 130 Clinical Presentations of clinical conditions and classifies them to assist in a problem-solving approach to diagnosis and management. The publication is recommended for use in preparing for the AMC Multiple Choice Question (MCQ) and Clinical Examinations. The publication is used as the AMC blueprint for classification of material within the AMC MCQ and Clinical bank databases.

- **AMC Handbook of Multiple Choice Questions – (805 pages published 2009)**

  The AMC publication *AMC Handbook of Multiple Choice Questions* contains more than 600 Multiple Choice Questions drawn from the AMC Examination banks. The handbook is designed for both self-directed learning and as a self test instrument in order to assist IMGs to prepare for the AMC MCQ Examination; to provide information covering all disciplines and clinical categories; and to facilitate IMGs entry to the medical workforce in Australia. As with the previous AMC publications, the *AMC Handbook of Multiple Choice Questions* is a comprehensive guide to the format, scope and standard of AMC Multiple Choice Question Examinations. All questions are

accompanied by commentaries on each response, details of best practice principles and correct answers.

- **AMC Handbook of Clinical Assessment – (894 pages published 2007)**

  The AMC publication *AMC Handbook of Clinical Assessment* is a comprehensive guide to clinical medical practice in Australia. Over 150 clinical examination tasks across the assessment domains of the AMC clinical examination have been included in the Handbook. It is designed around self-test clinical tasks with accompanying commentaries and performance guidelines reflecting best practice principles of clinical medicine.

Australia is unique in providing this level of comprehensive information regarding the content of its screening examination for registration purposes and guidance on best practice principles for IMGs.

Despite these initiatives, lack of compliance with application requirements remains a major contributing factor to the delays in processing applications and access to assessment processes. At the time of the COAG IMG assessment initiative (2007) it was estimated that only 1 in 20 applications for assessment was complete at the time of lodgement with the AMC. In 2008 the AMC implemented an on-line application process which has significantly reduced the number of incomplete applications. However, approximately 1 in 10 applications for specialist assessment is still incomplete at the time of receipt. [This appears to be a universal problem with the Medical Council of Canada reporting that only 1 in 5 of its applications for the licensure examination is complete at the time of receipt.]

PROCEDURAL CONSISTENCY – SPECIALIST ASSESSMENT AND REGISTRATION

Joint CPMAC/AMC Standing Committee on Overseas Trained Specialists (JSCOTS)

The specialist assessment pathway, from its outset has presented particular difficulties in ensuring consistency of assessment policy and process. As indicated earlier in this submission, there are a number of factors that have contributed to this situation. In 1999, in recognition of this problem, the Committee of President of Medical Colleges (CPMC) and the AMC (on behalf of the Medical Boards) established a Joint Standing Committee on Overseas Trained Specialists (JSCOTS) to bring together the Specialist Colleges and Medical Boards to facilitate the assessment and registration of overseas trained specialists. This Committee established core principles and issued a set of guidelines on specialist assessment to ensure consistency of process and reporting of assessment outcomes.

The work of JSCOTS was overtaken in 2000 by the Australian Consumer and Competition Commission (ACCC) investigation of the Royal Australasian College of Surgeons assessment processes. In 2006 JSCOTS was re-activated with addition representation from the jurisdictions and medical recruiters as part of the COAG IMG assessment initiative. The Committee will need to be re-constituted to reflect the establishment of the Medical Board of Australia and the new arrangements for registration under the National Law.

In 2010 JSCOTS, after consultation with relevant stakeholders, re-issued the original *Guidance for Colleges*, updated to reflect the outcome of the ACCC authorisation

reviews and the COAG IMG assessment initiative.

A copy of the current Guidance document is at **APPENDIX K.**

Administrative Processing Issues

Despite the work undertaken to improve the assessment processes for overseas trained specialists there are still some administrative, processing and communications challenges in this area. The following is a summary of the types of administrative and processing problems that appear in relation to the assessment and registration of overseas trained specialists:

- ***Duplication – Development of a Standard C.V Document:***

  A common CV document was developed by JSCOTS and well supported by the Specialist Colleges. However the MBA also has a standard CV document. As a result an applicant may submit the AMC/Specialist College approved CV document and complete the assessment only to find that he or she must complete the MBA standard CV document when applying for registration. [The AMC/Specialist College CV document was developed and approved prior to launch of MBA so this was not an issue at the time]. This process is open to criticism for unnecessary duplication and should be addressed when the JSCOTS is re-constituted.

- ***Combined area of need/specialist assessment:***

  Simultaneous assessment is an area where national consistency across specialties has not been achieved. Out of 14 assessing Specialist Colleges – six colleges do not complete combined area of need/specialist comparability assessment (ANZCA, ACEM, RACGP, CICM, RACMA, RANZCR). Although this is an area where moves have been made to improve processes, the fact that it has not been taken up by all Colleges leaves this area open to criticism that assessment processes are not nationally consistent.

- ***College interview processes:***

  The scheduling of interviews by Specialist Colleges has presented some problems. Although all outcomes are expected within 12 weeks, IMGs can have a difference of 10 weeks or more in getting an interview one or two days either side of a set date. Some Colleges schedule interviews on demand while others schedule on a monthly basis or at specified times. This in part reflects the different methods of operation of some Specialist Colleges but may also be linked to the limited resources available to support interviews. Again this is an area that would be referred to JSCOTS to consider.

- ***Duplication of Documentation:***

  The specialist assessment pathway is open to criticism that an IMG has to submit the same documents to as many as four different authorities, including a certified set to AMC, a certified set to the College (if requested), a certified set to the Medical Board and possibly a certified set to an employer. One option being considered by the AMC is a possibility for it and the Medical Board of Australia to share access to electronically scanned documents along similar lines to the process that currently applies to primary source verification of medical documents. If successful this could be extended to participating Colleges.

- ***Terminology:***

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

- ***Technical Considerations Impacting on National Consistency:***

  The fact that different Colleges apply different standards or processes to situations such as area of need assessment, suggests that there is a lack of national consistency. In fact there may be technical limitation or considerations that impact on the processes of the Colleges. By way of example, a challenge often brought against the College of Anaesthetists relates to that specialty not being able to isolate area of need capabilities or roles in the way that other Colleges, such as RANZCOG (Obstetricians and Gynaecologists) or RACS (Surgeons) are able to do. This relates specifically to the nature of anaesthetic practice and public safety which does not lend itself to the segmenting of tasks in the way that can be achieved in other specialties, where an IMG may be limited to certain procedural tasks.

- ***Consultation/Notice prior to policy changes:***

  A regular complaint to the AMC from recruiters, employers (the hospitals) or (previously) Medical Boards relates to significant policy changes or re-work assessment processes (e.g interviews) that are implemented without consultation or notice, other than posting on a website. Examples include changes to assessment fees or amendments to assessment processes. This would be better handled through the establishment of a protocol for appropriate notification to all parties of any substantial change in administrative arrangements or processes.

Accountability for the Assessment of Specialists Post-NRAS

In July 2010 the new National Registration and Accreditation Scheme came into operation[11]. The existing State and Territory Medical Boards were replaced by a new national Medical Board of Australia. As part of the new national scheme, the Australian Medical Council was appointed by the (Health) Ministerial Council as the external accreditation authority for the first three years of the new scheme. In this capacity the AMC is responsible for the accreditation of medical schools/courses for primary medical qualifications, the accreditation of specialist medical education and the assessment of overseas trained doctors for non-specialist registration.

The Medical Board of Australia, as part of the new arrangements, in July 2010 appointed the AMC-accredited specialist medical colleges to undertake the assessment of overseas trained specialists in their relevant fields of specialty for the purposes of registration under the provisions of sections 57 and 69 of the *Health*

[11] The scheme did no become fully operational until Western Australia enacted the necessary legislation in October 2010.

Practitioner Regulation National Law Act 2009. As a result of this decision, the Specialist Colleges now become directly accountable to the Medical Board of Australia for the assessment of overseas trained specialists.

In October 2010 the Medical Board of Australia announced that it would be working with the Australian Medical Council on a major review of the assessment pathways for overseas trained doctors leading to registration. The processes for the assessment and registration of specialists as well as the role, composition and reporting responsibilities of JSCOTS will be considered as part of this review.

BRIDGING PROGRAMS

The importance of bridging programs as a means of skills development and orientation to the Australian health care system to facilitate registration and employment has been recognised in every major review of overseas trained doctors from the 1982 Fry Report to the 2004 MTRP Report[12]. At one time or other every State has offered some form of bridging program for IMGs together with a number of programs funded by the Commonwealth. These have ranged from essentially pastoral support programs to provide assistance to individual IMGs, to highly structured and educationally sound training programs focussed on either the AMC MCQ or clinical examinations.

As the 2004 MTRP Report found, the major limiting factor in the provision of bridging programs has been funding.[13] A feature of many of the government funded programs was the need to demonstrate the effectiveness of the courses. As a result many of the course providers implemented front-end screening processes to select the applicants most likely to succeed in the relevant MCQ or clinical examinations. However, many of these candidates were likely to pass these examinations without the need for further bridging, which meant that places in bridging courses were denied to candidates who could best benefit from skills refreshes training or remediation.[14]

In almost all cases these programs have resulted in improved pass rates at the AMC examinations, where the bridging courses and the examinations were linked. As the time between completion of the bridging course and the relevant examination increases the pass rates tend to decline. In recognition of this, the AMC set aside clinical examination places for AMC candidates who were registered with established bridging programs. However, as the demand for clinical examination has risen to the present levels of a ratio of approximately 5 to 1 applications to available places, it is no longer possible to reserve clinical examination places for bridging course participants. The AMC would like to re-introduce the linking of bridging course places to clinical examination places as soon as it can increase the availability of clinical examination places or satisfy the demand through the Workplace-based Assessment pathway.

[12] Medical Training and Review Panel Overseas Trained Doctors Subcommittee Report February 2004
[13] MTRP p39-40.
[14] The 1999 ARTD study of bridging courses found that bridging courses were not relevant for one third of candidates who would pass the AMC clinical examination at the first attempt. ARTD p.47

ORIENTATION

The 2007 COAG IMG assessment initiative proposed that all IMGs be required to complete a mandatory accredited orientation program as a formal requirement for registration. In the absence of sufficient orientation programs, the mandatory requirement for orientation was deleted from the final recommendations on the consistent national assessment processes. However, the then Medical Boards required that within three months or registration and IMG would be required to participate in an orientation program that would be reported to the relevant Board.

The AMC considers that orientation program developed by Queensland Health under their Recruitment, Assessment, Placement, Training and Support for International Medical Graduates (RAPTS) scheme is an example of best practice in this area and commends it as a model for other jurisdictions to adopt. An extract of the RAPTS Orientation Program is enclosed at **APPENDIX L**.

ROLLOUT OF THE STANDARD PATHWAY (WORKPLACE-BASED ASSESSMENT)

The most innovative development to emerge from the 2007 COAG IMG assessment initiative, besides the Competent Authority assessment pathway, was the Standard Pathway (Workplace-based Assessment). In this option the AMC clinical examination is replaced with an equivalent, formally accredited assessment that is undertaken in the workplace setting of the individual IMG. This model offers a number of advantages over the AMC clinical examination pathway:

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

Although the Workplace-based Assessment pathway was approved as part of the COAG IMG assessment initiative, as reported above it was not generally taken up and supported by jurisdictions, other than Western Australia. There may be a number of reasons why this was the case, including a lack of familiarity with assessment processes, concerns at the cost and complexity of rolling out a workplace-based model of assessment and the potential impact on already stretched clinical resources.

The four trial sites for the workplace-based assessment have already demonstrated the positive workforce incentive that is available through this assessment pathway. The Launceston Hospital which has a capacity for 8 area of need positions, has received application from 10 IMGs not currently working in the hospital and inquiries from 20 more potential candidates. Western Australia Health which has placed 14 IMGs in the workplace-based assessment program at Bunbury Hospital has received 164 applications from IMGs wanting to participate in the workplace-based program in

WA. As a result of this a further workplace-based assessment site in WA is being activated. The Hunter New England Area Health Service in New South Wales has just completed the assessment of the first cohort of 27 IMGs through the workplace-based assessment program with a second cohort of 24 candidates to commence in February 2011 and a third cohort of 30 candidates expected to commence in June. The Hunter New England Area Health Service has received more than 100 enquiries from IMGs to participate in the program.

The Standard Pathway (Workplace-based Assessment) from both a workforce perspective as well as an assessment perspective, has clear advantages over other models of recognition for non-specialist IMGs. Given the well documented difficulties of developing, funding and maintaining bridging programs and other support services for IMGs, the effectiveness of the workplace-based assessment model deserves further consideration and support by the jurisdictions. There will still be a need to maintain an assessment pathway for those IMGs who are not able to secure appointments within the health care system. These individuals will still require support and orientation to facilitate their entry to the medical workforce.

THE SUPERVISION CHALLENGE

A critical element in the development of more efficient processes for the assessment and registration of IMGs is the availability of appropriate supervision. This is particularly the case if more flexible or streamlined assessment processes are to be developed where the critical roll of monitoring standards shifts from the initial screening of applicants to the review and monitoring of performance. The rollout of Health Workforce Australia and its programs is bringing focus and resources to bear on the issue of supervision. It is important to note that the term "supervision" covers a number of roles in the clinical setting, including providing instruction, monitoring and report on performance and mentoring individual practitioners. In strengthening the supervision capacity within the healthcare system, all of these roles need to be considered.

RECOGNITION OF PRIOR TRAINING, ASSESSMENT AND EXPERIENCE AND SPECIALIST REGISTRATION

In 2007 the Competent Authority assessment model was adopted in Australia based on the recognition of prior assessment and prior accredited training. As reported above the model was limited to countries with a similar context of clinical practice, professional standards and systems of medical education. While it is important to note that specialist medical practice is more complex and provides greater challenges to developing a system of advanced standing similar to the Competent Authority model for non-specialist, the experience with the CA pathway suggests that there may be scope for development of more efficient models of specialist recognition than are currently in place. However, for this occur the following will be required:

- sufficient flexibility in registration processes to allow for overseas trained specialists to be registered in a way that allows them to practise at an appropriate "specialist" level
- suitable posts in sufficient numbers for appropriate overseas trained specialists to work under appropriate oversight
- an appropriate system of qualified supervision to monitor performance and safety.

If automatic recognition of prior specialist training is to be implemented, it may require an extension of the existing AMC specialist accreditation processes or some modification of the accreditation process. However, it should be noted that in 2006 the Joint (CPMC/AMC) Standing Committee on Overseas Trained Specialists (JSCOTS) proposed from a public safety perspective, that every first registration in the Australian health care system should include a period of 'provisional' registration under supervision or oversight. This already applies to all local graduates who are required to complete an internship prior to general registration and to all Competent Authority IMGs who complete 12 months in a structured supervision program prior to general registration. A number of Specialist Colleges have already implemented this provision with the requirement that overseas trained specialists who have been assessed as "substantially comparable" be required to complete a period of 12 months "under oversight" prior to being registered to undertake independent practise as a specialist.

CONCLUSION – WAY FORWARD

The assessment and registration of international medical graduates is a complex process that needs to balance the, at times, conflicting interests of standards and workforce supply. Various pathways and processes had been developed over time to meet the needs of individual jurisdictions and to reflect differences in the qualifications and experience of individual overseas trained doctors. The pathways to registration and the associated assessment processes that have confronted the overseas trained doctor in many cases have been confusing and difficult to navigate. Some of the initiatives and programs intended to support IMGs have been limited by funding and in some cases have targeted the wrong groups. The focus has often been on passing examinations and securing registration, rather than providing ongoing support to IMGs and facilitating their integration to the medical workforce in Australia.

The regulatory reforms initiated by the Council of Australian Governments in 2006 leading to the National Registration and Accreditation Scheme and the 2007 COAG initiative to achieve nationally consistent assessment processes for IMGs, represent a significant advance in this area. These reforms have themselves been complex and difficult to implement. However, with the establishment of the Medical Board of Australia as part of the national registration scheme for health professionals and continuing development of the assessment processes from the 2007 COAG initiative, there is now a possibility of creating genuinely consistent national policies and procedures for the assessment and registration of IMGs in Australia.

The experiences of the Australian Medical Council with the assessment of overseas trained specialists since 1993 and with the implementation of the 2007 COAG assessment initiatives confirms the importance of effective communication between the key stakeholders to ensure that assessment processes are properly implemented. This was recognised in 2007 with the establishment of the AHMAC Implementation Committee to oversee the development of the COAG assessment initiatives. This Committee had representation from the Commonwealth and the States, Specialist Colleges, Medical Boards, the profession, employers and the Australian Medical Council. It provided a forum to consider and review the range of new initiatives and processes that were being developed over a very short time line (6 months). It also provided an opportunity to identify obstacles and impediments to the roll-out of individual elements of the COAG initiative. Similarly, the Joint Standing Committee on Overseas Trained Specialists has been able to focus on problems or issues that have emerged in the assessment of overseas trained specialists by the Colleges and registration issues identified by the Medical Boards. In this capacity JSCOTS played a pivotal role in the implementation of the new procedures for the assessment and registration of new category of "Specialist in Training" in 2008.

The AMC considers that there is a strong case for the establishment of an appropriate oversight group, possibly an extension of the Joint Standing Committee on Overseas Trained Specialists or a re-constituted AHMAC Implementation Committee, to bring together the key stakeholders in the assessment, registration and on-going support of overseas trained medical practitioners. This, together with the initiatives that are being developed or are already in place, would facilitate consistent national approaches to the recognition of international medical graduates.

Canberra
4 February 2011

Appendix A

Final Report – Implementation Committee for the Nationally Consistent Assessment of Overseas Trained Doctors

IMPLEMENTATION COMMITTEE FOR THE NATIONALLY CONSISTENT ASSESSMENT OF OVERSEAS TRAINED DOCTORS

FINAL REPORT

Nationally Consistent Assessment Model for International Medical Graduates (IMGs).

1. The Implementation Committee has agreed on the following detailed features of the nationally consistent assessment model, comprising the Competent Authority pathway, the standard pathways and the specialist pathway. This report specifies the steps in the agreed assessment pathways and refers to documents developed by the Australian Medical Council (AMC) and Joint Medical Boards Advisory Committee (JMBAC) which provide the detailed procedures.

2.1. The new assessment model provides a variety of pathways to registration depending on the International Medical Graduate's (IMGs) previous training and assessment, knowledge base, clinical skills, and the suitability of their skills and experience for the position for which they are applying. Within each pathway assessment will be according to the relative risk of each position. The risk assessment matrices, together with a preamble and a glossary of terms for each pathway are at **Attachment 1**.

2.2. There are four main pathways.
The first three pathways are based on assessment of primary qualifications and experience:
- the Competent Authority pathway;
- two standard pathways:
    (i) a new AMC accredited workplace assessment pathway (the 'workplace assessment pathway') and
    (ii) the current AMC examination based pathway.

The fourth pathway is based on assessment of specialist qualifications and experience:
- the specialist pathway is intended for specialists and vocational trainees.

2.3 All pathways have a number of common elements which have already been agreed by all medical boards and the AMC. Some of these elements are already in place and are compulsory, some will be introduced from 1 July 2007, and some are available but not yet compulsory. The standard pathways and specialist pathways are still in formative stages and will go to the Technical Committee for further development. Terms of reference for the Technical Committee are at **Attachment C** of this agenda paper.

2.4. **Competent Authority pathway**: Doctors who complete training and assessment through AMC-accredited Competent Authorities are eligible to apply for 'advanced standing' toward the AMC Certificate. If the AMC grants advanced standing status to the individual, he or she is not required to sit the AMC Multiple Choice Questionnaire (MCQ) or AMC clinical examinations, but will undergo AMC accredited workplace based assessment whilst working under supervision. Requirements for the type of workplace assessments while working under supervision will be determined or based on position requirements and individual applicant's experience.

2.5 The AMC is reviewing international examinations and medical schools and courses that lead to registration for the purpose of accrediting those that meet set criteria as "Competent Authorities". The AMC has provided a preliminary list of Competent Authorities, available on the AMC website from 1 July 2007. Additional Competent Authorities will be listed on the

AMC website as they are successfully reviewed. The criteria for a Competent Authority is at **Attachment 2**, and current list of Competent Authorities is at **Attachment 3**. The AMC anticipates that further authorities will be reviewed/ added over time.

2.6. The period of supervision for IMGs assessed through the Competent Authority pathway has initially been set at 12 months. The required period of supervision may be reduced when AMC-accredited workplace based assessments are introduced. The type of workplace assessment required while working under supervision will be determined or based on position requirements and individual applicant's experience. The risk matrix for the Competent Authority pathway is at **Attachment 1, Appendix 1.**

2.7. The **Competent Authority** pathway requirements are listed below:

(a) Evidence of English language proficiency - details available on the AMC website and at **Attachment 4.**

(b) Primary source verification of medical qualifications though the International Credentials Service of the Educational Commission for Foreign Medical Graduates of the United States (ECFMG). This may be completed concurrently with assessment, but evidence of application for Primary Source Verification must be supplied for conditional registration by a Medical Board (**Attachment 5**).

(c) Award of advanced standing towards the AMC certificate based on evidence of possession of qualifications and clinical experience from an AMC-accredited Competent Authority (List of AMC-accredited competent authorities is at **Attachment 3).**

(d) Pre-employment assessment of suitability for position determined by employer, which may be assisted by a college assessment of prior knowledge, learning and skills, and based on an assessment of qualifications and experience against a position description. Examples of position description forms for GP and hospital positions are at **Attachments 6 & 7.** For many IMGs with advanced standing, in low-risk placements (eg accredited hospital-based positions), once basic competence and employment suitability is established IMGs are eligible for conditional registration. Further work will be done by the Technical Committee on the feasibility of specifying the minimum data set requirements for position description forms.

(e) Where the medical board determines a pre-employment structured clinical interview is required, it will be carried out by an AMC-accredited provider against the position description. The position description together with the qualifications, training and experience of the applicant will determine the level of risk and the level of further assessment required. See **Attachment 8 – AMC Pre-employment Clinical Interview guidelines**.

(f) Conditional registration - for up to 12 months initially, with regular supervision reports to medical board. The broad principles of supervision requirements and suggested format for supervision report are at **Attachment 9**. The Australian Health Ministers' Advisory Council (AHMAC) has noted the recommendation that indemnity be provided under the proposed national registration scheme for supervisors and assessors.

(g) The provision of workplace, cultural and health system orientation is the responsibility of the employer to provide within three months of employment. The

supervision and assessment plan submitted with the initial registration application will require the employer to indicate how the IMG will be orientated. Evidence of completion of a satisfactory orientation program must be submitted to the relevant medical board with a supervisory report. An outline of the material required in a satisfactory orientation program is at **Attachment 10**.

(h) Workplace-based assessment will occur during the first 12 months of conditional registration. The AMC will accredit the workplace assessment processes to ensure that the workplace based assessment is valid, reliable and defensible. The AMC guidelines for accreditation of workplace based assessments are at **Attachment 11**.

(i) After successful completion of the workplace-based assessment, the IMG may seek award of the AMC certificate which entitles the IMG to seek general registration in participating jurisdictions.

(j) Annual renewal of registration dependent on meeting board requirements including evidence of Continuing Professional Development (CPD) for annual renewal of registration where required by legislation. Principles of CPD are at **Attachment 12**. AHMAC has agreed that CPD will be compulsory.

(k) Information on new assessment procedures will be available on participating medical board, departmental and AMC websites. The initial information will be based on the Fact Sheet template (**Attachment 13**) modified as necessary for each jurisdiction.

(l) Transitional/grandparenting arrangements will be developed in each jurisdiction taking into account existing legislation and procedures. Information on the transitional arrangements will be available on multiple sites, including participating medical board websites, the Health Workforce Principal Committee (HWPC) website and AMC website **(Attachment 14).**

2.8. The Competent Authority pathway will be independently evaluated and the results of the evaluation provided to the HWPC via the Technical Committee.

2.9. **Standard (workplace assessment) pathway**: This assessment pathway is primarily intended for doctors who are not eligible for the Competent Authority pathway or specialist pathways. Doctors who have obtained qualifications from authorities which are not presently on the AMC Competent Authority list will be required to undertake a mandatory screening examination followed by further assessment in line with the risk matrix at **Attachment 1, Appendix 1.**

2.10. The Standard (Workplace Assessment) pathway details are listed below:

(a) Evidence of English Language proficiency – **(Attachment 4)**

(b) Primary source verification of medical qualifications though the International Credentials Service of the Educational Commission for Foreign Medical Graduates of the United States (ECFMG). This may be completed concurrently with assessment, but evidence of application for Primary Source Verification must be supplied for conditional registration by a medical board. **(Attachment 5)**

(c) Success in the mandatory screening examination of essential medical knowledge completed either on-shore or off-shore. The screening examination may be either the AMC Multiple Choice Question or an alternative examination accepted as equivalent by the AMC. The list of screening examinations and locations is available on the AMC website.

(d) Pre-employment assessment of suitability for position determined by employer, and based on an assessment of qualifications and experience against a position description. Examples of position description forms are at **Attachments 6 & 7 .**

(e) Where the medical board determines that a pre-employment Structured Clinical Interview is required, the interview will be against the position description form, carried out by an AMC accredited provider, with the level of stringency of assessment and supervision requirements according to the risk matrix **(Attachment 1).** The position description together with the qualifications training and experience of the applicant will determine the level of risk and the level of assessment required.

(f) Conditional registration - For up to 12 months initially, with regular supervision reports to medical board. The broad principles of supervision requirements are at **Attachment 9**. AHMAC has noted the recommendation that indemnity be provided under the proposed national registration scheme for supervisors and assessors.

(g) The provision of workplace, cultural and health system orientation is the responsibility of the employer to provide within three months of employment. The supervision and assessment plan submitted with the initial registration application will require the employer to indicate how the IMG will be orientated. Evidence of completion of a satisfactory orientation program must be submitted to the relevant medical board with a supervisory report. An outline of the material required in a satisfactory orientation program is at **Attachment 10**.

(h) Success in the AMC clinical examination or an alternative clinical skills examination accepted as equivalent by the AMC will enable the IMG to seek award of the AMC certificate which entitles the IMG to seek general registration. A description of the areas covered by the AMC clinical examination is at **Attachment 15**. It is anticipated that over time the AMC accredited workplace based assessments and assessing bodies will be an alternative to the current AMC clinical examination. Principles of workplace based assessment are at **Attachment 11**.

(i) Annual renewal of registration dependent on meeting board requirements including evidence of CPD for annual renewal of registration where required by legislation. Principles of CPD are at **Attachment 12**. AHMAC has agreed that CPD will be compulsory.

(j) Information on new assessment procedures will be available on participating Medical Board, Departmental, College and AMC websites as the procedures are introduced. The information will be based on a template developed by the Technical Committee and modified as necessary for each jurisdiction.

(k) Transitional arrangements will be developed in each jurisdiction taking into account existing legislation and procedures. Information on the transitional arrangements will be

available on multiple sites, including participating Medical board websites, the HWPC website and the AMC website.

2.11 Standard (AMC Examination) Pathway

This is a currently existing pathway which is described in detail in **Attachment 1, Appendix 4.**

2.12. **Specialist assessment pathway.** This assessment pathway is intended for specialists in a range of positions including specialists who are eligible for Fellowship, teaching and research positions, advanced trainees positions and Area of Need positions for specialists who are partially comparable or substantially comparable. This pathway also includes general practitioners seeking Fellowship of the appropriate colleges. The risk matrix for specialist assessment is at **Attachment 1, Appendix 3.**

2.12 IMGs who are in Australia on an occupational trainee visa who fulfil the requirements of specialist or advanced trainee positions as specified in **Attachment 16**, will be assessed under the specialist pathway.

2.13. As will be seen from the risk matrix, should they choose to do so, some IMGs on the specialist pathway who have obtained registration under a Competent Authority will be eligible to be further assessed for either specialist registration through the specialist assessment pathway and/or general registration under the Competent Authority pathway.

2.14. **Specialist pathway details** are listed below and in the risk matrix at **Attachment 1, Appendix 3.**

(a) Evidence of English language proficiency – **Attachment 4.**

(b) Primary source verification of medical qualifications though the International Credentials Service of the Educational Commission for Foreign Medical Graduates of the United States (ECFMG). This may be completed concurrently with assessment, but evidence of application for primary source verification must be supplied for conditional registration by a medical board - **Attachment 5.**

(c) Pre-employment assessment of suitability for position determined by employer, which will be assisted by a college assessment of prior knowledge, learning and skills, and based on an assessment of qualifications and experience against a position description. Examples of position description forms are at **Attachments 6 & 7.**

(d) Concurrent assessment for suitability for Area of Need specialist position/comparability to an Australian trained specialist, carried out according to the standards and proformas developed by the Joint Standing Committee on Overseas Trained Specialists (JSCOTS) - **Attachment 17**. Assessment is currently via a variety of methods according to college.

(g) Conditional registration - for up to 12 months initially, with regular supervision reports to medical board. The broad principles of supervision requirements are at **Attachment 9**. AHMAC has noted the recommendation that indemnity be provided under the new scheme for supervisors and assessors.

(h) The provision of workplace, cultural and health system orientation is the responsibility of the employer to provide within three months of employment. The supervision and assessment plan submitted with the initial registration application will require the employer to indicate how the IMG will be orientated. Speciality-specific orientation will be provided by the relevant specialist college. Evidence of completion of a satisfactory orientation program must be submitted to the relevant medical board with a supervisory report. An outline of the material required in a satisfactory orientation program is at **Attachment 10**.

(k) Annual renewal of registration dependent on meeting board requirements including evidence of CPD for annual renewal of registration where required by legislation. Principles of CPD are at **Attachment 12**. AHMAC has agreed that CPD will be compulsory.

(l) Information on new assessment procedures will be available on participating medical board, departmental, specialist college and AMC websites. The information will be based on a template provided by the Technical Committee and modified as necessary for each jurisdiction.

(k) Transitional arrangements will be developed in each jurisdiction taking into account existing legislation and procedures. Information on the transitional arrangements will be available on multiple sites, including participating medical board websites, specialist college websites, the Health Workforce Principal Committee website and AMC website.

Appendix B

Competent Authorities Pathway Statistics by Examination Type
01-07-2007 to 31-12-2010

Competent Authorities Pathway Statistics By Exam Type

01-07-2007 to 31-12-2010

Generated on 21-01-2011 16:46:07

Country Trained	Number of Applications Received by Competent Authority							No of Adv Std Issued	No of Cert Issued
	PLAB	MCC	USMLE	NZREX	GMCUK	MCI	Total No. of Application		
AFGHANISTAN	1	0	0	0	0	0	1	1	0
ALBANIA	1	0	0	0	0	0	2	1	0
ANTIGUA AND BARBUDA	0	0	0	0	0	0	1	0	0
ARMENIA	3	0	0	0	0	0	5	3	2
AUSTRIA	1	0	0	0	0	0	1	0	1
BAHRAIN	1	0	0	0	0	0	1	0	0
BANGLADESH	23	8	1	8	0	0	42	22	22
BELARUS	1	0	0	0	0	0	2	0	1
CANADA	0	72	3	0	0	0	84	60	8
CHILE	2	0	0	0	0	0	2	1	2
CHINA	0	1	0	4	0	0	5	4	1
COLOMBIA	2	0	0	1	0	0	3	3	1
CROATIA	1	0	0	2	0	0	3	2	0
CZECH REPUBLIC	4	0	0	0	0	0	6	4	2
DOMINICA	0	0	1	0	0	0	1	0	0
DOMINICAN REPUBLIC	1	0	0	0	0	0	1	1	1
EGYPT	10	14	2	5	1	0	35	26	6
FIJI	0	1	0	1	0	0	3	1	1
FRANCE	0	0	0	0	0	0	1	0	0
GERMANY	1	0	2	1	1	0	9	2	3
GHANA	2	0	0	0	0	0	6	1	4
GREECE	0	0	0	0	0	0	1	0	0
GRENADA	1	0	2	0	0	0	5	1	2
GUYANA	1	0	0	0	0	0	1	1	1
HONG KONG	0	0	0	0	0	0	1	0	0
HUNGARY	0	1	0	0	0	0	3	1	0
INDIA	483	8	9	20	1	0	576	290	422
INDONESIA	1	0	0	0	0	0	1	1	1
IRAN	15	6	1	1	0	0	25	15	11
IRAQ	27	9	0	9	0	0	48	31	18
IRELAND	0	1	2	0	1	564	626	481	172
ISRAEL	0	0	1	0	0	0	1	1	0
ITALY	1	0	0	0	0	0	1	0	1
JAMAICA	0	0	0	0	0	0	1	0	1
JORDAN	8	0	1	0	0	0	10	6	2
LATVIA	3	0	0	0	0	0	4	2	4
LEBANON	0	0	1	1	0	0	2	2	1
LIBYA	4	1	0	0	0	0	6	4	3
LITHUANIA	1	0	0	0	0	0	1	0	0
MACEDONIA	0	0	0	1	0	0	1	0	1
MALAYSIA	1	0	0	0	0	0	2	1	2
MYANMAR	51	0	0	1	0	0	55	22	44
NEPAL	11	0	0	0	0	0	11	10	7
NETHERLANDS	0	0	1	0	0	0	1	1	0

	Number of Applications Received by Competent Authority								
Country Trained	**PLAB**	**MCC**	**USMLE**	**NZREX**	**GMCUK**	**MCI**	**Total No. of Application**	**No of Adv Std Issued**	**No of Cert Issued**
NETHERLANDS ANTILLES	0	0	1	0	0	0	2	1	0
NEW ZEALAND	0	0	0	1	0	0	2	0	0
NIGERIA	23	6	2	1	0	0	40	23	11
OMAN	0	1	0	0	0	0	1	1	0
PAKISTAN	108	11	5	3	1	1	147	84	78
PERU	2	0	0	0	0	0	2	0	2
PHILIPPINES	8	0	3	2	0	0	15	9	7
POLAND	2	0	1	1	0	0	6	3	4
ROMANIA	8	0	0	1	0	0	12	7	5
RUSSIA	18	2	0	1	0	0	24	17	14
SAINT LUCIA	0	0	1	0	0	0	1	1	0
SAUDI ARABIA	0	3	0	0	0	0	4	1	0
SERBIA	0	0	0	5	0	0	5	4	4
SINGAPORE	0	0	1	0	0	0	2	1	0
SLOVAK REPUBLIC	1	0	0	1	0	0	2	1	1
SOMALIA	0	2	0	0	0	0	2	2	0
SOUTH AFRICA	5	17	1	3	0	0	33	18	12
SOUTH KOREA	0	0	0	1	0	0	2	0	1
SRI LANKA	53	2	1	8	0	0	71	38	46
SUDAN	10	1	0	0	0	0	11	7	8
SWEDEN	0	0	1	0	0	0	1	1	1
SYRIA	5	0	0	0	0	0	5	5	2
TANZANIA	1	0	0	0	0	0	1	0	0
TRINIDAD AND TOBAGO	2	0	0	0	0	0	3	2	1
TURKEY	2	1	0	1	0	0	4	1	2
UGANDA	2	0	0	0	0	0	2	2	2
UKRAINE	14	0	0	1	0	0	17	13	7
UNITED KINGDOM	0	2	0	0	2632	2	2819	2002	1026
USA	1	0	76	0	0	0	96	63	9
UZBEKISTAN	0	0	0	1	0	0	1	1	0
VENEZUELA	2	0	0	0	0	0	2	2	1
VIET NAM	0	1	0	0	0	0	1	1	0
YEMEN	1	0	0	0	0	0	1	1	0
ZAMBIA	7	0	0	0	0	0	7	6	3
ZIMBABWE	15	0	0	0	0	0	16	8	14
Total	952	171	120	86	2637	567	4957	3328	2009

Appendix C

Competent Authorities Pathway Statistics by Examination Type
01-01-2010 to 31-12-2010

Competent Authorities Pathway Statistics By Exam Type

01-01-2010 to 31-12-2010

Generated on 21-01-2011 17:05:23

	Number of Applications Received by Competent Authority								
Country Trained	PLAB	MCC	USMLE	NZREX	GMCUK	MCI	Total No. of Application	No of Adv Std Issued	No of Cert Issued
ANTIGUA AND BARBUDA	0	0	0	0	0	0	1	0	0
ARMENIA	1	0	0	0	0	0	2	2	0
BANGLADESH	4	2	0	1	0	0	7	6	5
BELARUS	1	0	0	0	0	0	1	0	0
CANADA	0	25	1	0	0	0	31	23	2
CHILE	1	0	0	0	0	0	1	0	1
CHINA	0	1	0	1	0	0	2	2	0
COLOMBIA	0	0	0	1	0	0	1	1	1
CZECH REPUBLIC	2	0	0	0	0	0	2	2	0
DOMINICA	0	0	1	0	0	0	1	0	0
DOMINICAN REPUBLIC	0	0	0	0	0	0	0	0	1
EGYPT	1	6	1	0	1	0	10	10	0
GERMANY	0	0	0	0	1	0	2	1	1
GRENADA	1	0	0	0	0	0	2	0	1
GUYANA	0	0	0	0	0	0	0	1	1
HUNGARY	0	1	0	0	0	0	1	1	0
INDIA	50	1	3	4	1	0	66	53	85
IRAN	2	6	0	0	0	0	8	8	1
IRAQ	2	4	0	1	0	0	7	7	5
IRELAND	0	0	1	0	1	167	193	182	65
ISRAEL	0	0	1	0	0	0	1	1	0
JORDAN	2	0	0	0	0	0	3	2	0
LEBANON	0	0	0	0	0	0	0	0	1
LIBYA	0	1	0	0	0	0	1	1	0
MYANMAR	5	0	0	0	0	0	5	6	4
NEPAL	1	0	0	0	0	0	1	1	4
NETHERLANDS ANTILLES	0	0	1	0	0	0	1	1	0
NEW ZEALAND	0	0	0	1	0	0	2	0	0
NIGERIA	4	1	0	1	0	0	11	6	4
OMAN	0	1	0	0	0	0	1	1	0
PAKISTAN	19	8	0	2	1	0	36	28	23
PHILIPPINES	4	0	0	0	0	0	4	4	2
POLAND	0	0	1	0	0	0	2	1	0
ROMANIA	2	0	0	0	0	0	2	1	0
RUSSIA	4	0	0	0	0	0	4	5	5
SAINT LUCIA	0	0	0	0	0	0	0	1	0
SAUDI ARABIA	0	0	0	0	0	0	1	0	0
SOMALIA	0	1	0	0	0	0	1	1	0
SOUTH AFRICA	0	5	1	0	0	0	7	8	3
SRI LANKA	7	2	1	4	0	0	16	14	6
SYRIA	1	0	0	0	0	0	1	1	0
TRINIDAD AND TOBAGO	1	0	0	0	0	0	1	1	0

	Number of Applications Received by Competent Authority								
Country Trained	PLAB	MCC	USMLE	NZREX	GMCUK	MCI	Total No. of Application	No of Adv Std Issued	No of Cert Issued
TURKEY	0	0	0	0	0	0	0	0	1
UKRAINE	4	0	0	1	0	0	5	4	3
UNITED KINGDOM	0	0	0	0	769	2	873	780	277
USA	0	0	25	0	0	0	31	27	5
UZBEKISTAN	0	0	0	1	0	0	1	1	0
VENEZUELA	1	0	0	0	0	0	1	1	1
VIET NAM	0	1	0	0	0	0	1	1	0
YEMEN	1	0	0	0	0	0	1	1	0
ZAMBIA	2	0	0	0	0	0	2	2	1
ZIMBABWE	1	0	0	0	0	0	1	0	4
Total	124	66	37	18	774	169	1355	1200	513

Appendix D

Financial Year Summary of Number of Candidates and Attempts at Examinations Conducted for Overseas Trained Medical Practitioners

Summary of Number of Candidates & Attempts at Examinations Conducted for Overseas Trained Medical Practitioners

Generated on : 14/12/2010 at : 10:35:04 AM

	MCQ			Clinical		
Financial Year	Newly Presenting	Sitting	Passed	Newly Presenting	Sitting	Completed
1978/1979	174	199	118	96	104	35
1979/1980	125	170	104	73	100	28
1980/1981	91	152	88	51	85	26
1981/1982	90	146	75	47	78	30
1982/1983	118	191	76	59	107	55
1983/1984	111	191	74	73	150	68
1984/1985	122	219	85	82	149	75
1985/1986	143	264	111	111	214	79
1986/1987	253	447	69	65	190	83
1987/1988	192	424	88	64	137	64
1988/1989	282	501	122	93	168	85
1989/1990	392	653	326	187	281	131
1990/1991	538	915	455	279	391	194
1991/1992	523	921	298	344	587	246
1992/1993	343	811	297	192	434	193
1993/1994	332	619	343	190	418	211
1994/1995	350	688	391	203	404	222
1995/1996	0	0	0	286	518	266
1996/1997	758	1382	612	335	556	266
1997/1998	300	779	234	265	427	151
1998/1999	301	669	372	250	459	220
1999/2000	450	769	304	242	434	219
2000/2001	666	1051	628	300	548	291
2001/2002	522	884	499	363	619	319
2002/2003	528	883	551	403	589	360
2003/2004	544	859	487	519	711	438
2004/2005	672	982	623	567	842	552
2005/2006	1075	1509	908	738	887	569
2006/2007	1819	2494	1355	605	895	586
2007/2008	1888	2695	1454	854	1071	711
2008/2009	3112	4646	2366	895	1194	714
2009/2010	2610	4466	2258	936	1258	806
2010/2011	1304	2146	1134	695	958	562
Totals	**20728**	**33725**	**16905**	**10462**	**15963**	**8855**

Note: If a Candidate passed the MCQ more than once, or had multiple attempts that met Minimum Performance Levels, ALL are counted!

Appendix E

MCQ – Country of Training Statistics – All Candidates
01-01-1978 to 31-12-2010

MCQ - Country of Training Statistics - All Candidates

01-01-1978 to 31-12-2010

Generated on 21-01-2011 22:47:14

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
AFGHANISTAN	100	59	35	77	271	34	21	9	18	82
ALBANIA	6	4	3	1	14	1	1	1	1	4
ALGERIA	7	6	6	7	26	1	0	1	3	5
ANTIGUA AND BARBUDA	1	0	0	0	1	0	0	0	0	0
ARGENTINA	35	23	12	10	80	13	11	5	4	33
ARMENIA	7	3	0	0	10	2	2	0	0	4
AUSTRALIA	5	1	0	0	6	3	1	0	0	4
AUSTRIA	38	10	3	0	51	25	4	2	0	31
AZERBAIJAN	4	3	2	5	14	1	1	1	1	4
BAHRAIN	3	0	0	0	3	2	0	0	0	2
BALEARIC ISLANDS	2	1	0	0	3	1	0	0	0	1
BANGLADESH	1006	339	141	128	1614	581	172	49	60	862
BELARUS	30	14	7	5	56	14	5	4	1	24
BELGIUM	27	7	4	2	40	19	3	3	0	25
BELIZE	1	1	0	0	2	0	0	0	0	0
BOLIVIA	5	2	2	1	10	0	0	1	1	2
BOSNIA-HERZEGOVINA	88	61	39	41	229	22	19	14	17	72
BRAZIL	69	27	16	11	123	41	8	5	3	57
BULGARIA	78	41	23	25	167	26	15	10	7	58
CAMBODIA	13	8	3	4	28	3	4	1	2	10
CAMEROON	1	0	0	0	1	1	0	0	0	1
CANADA	58	9	4	3	74	48	5	2	1	56
CAYMAN ISLANDS	6	2	0	0	8	3	0	0	0	3
CHILE	16	6	3	0	25	9	2	3	0	14
CHINA	943	391	142	111	1587	471	201	64	45	781
COLOMBIA	100	37	15	6	158	49	19	10	1	79
CROATIA	56	35	15	33	139	19	12	3	12	46
CUBA	5	2	0	0	7	2	0	0	0	2
CZECH REPUBLIC	28	16	3	1	48	8	8	1	1	18
CZECHOSLOVAKIA	52	30	18	7	107	15	13	9	4	41
DEMOCRATIC REPUBLIC OF THE CONGO	4	1	1	0	6	2	0	1	0	3
DENMARK	17	6	0	0	23	8	5	0	0	13
DOMINICA	3	2	0	0	5	1	0	0	0	1
DOMINICAN REPUBLIC	10	6	3	0	19	3	2	1	0	6
ECUADOR	11	7	2	4	24	4	5	1	1	11
EGYPT	991	464	235	300	1990	423	201	97	104	825
EL SALVADOR	15	10	6	5	36	1	3	1	2	7
ESTONIA	2	1	0	0	3	1	1	0	0	2
ETHIOPIA	20	3	1	0	24	15	2	1	0	18
FIJI	178	77	34	46	335	86	32	13	16	147
FINLAND	6	1	0	0	7	4	1	0	0	5
FRANCE	39	13	6	8	66	18	4	2	3	27
GEORGIA	8	2	2	0	12	2	0	0	0	2
GERMANY	378	100	33	20	531	240	56	19	10	325

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
GHANA	12	4	1	0	17	7	2	1	0	10
GREECE	34	15	10	13	72	11	3	2	3	19
GRENADA	9	5	1	0	15	4	2	1	0	7
GUATEMALA	7	6	4	2	19	0	1	1	1	3
GUINEA	1	0	0	0	1	0	0	0	0	0
GUYANA	2	0	0	0	2	2	0	0	0	2
HONG KONG	255	36	8	1	300	196	24	7	1	228
HUNGARY	72	35	21	28	156	28	11	9	4	52
ICELAND	1	1	0	0	2	0	1	0	0	1
INDIA	3853	1343	534	511	6241	2059	687	255	182	3183
INDONESIA	108	53	24	34	219	34	18	11	9	72
IRAN	866	244	63	31	1204	522	155	30	19	726
IRAQ	645	162	47	41	895	441	107	22	16	586
IRELAND	165	38	11	6	220	112	24	8	1	145
ISRAEL	12	3	3	7	25	5	0	1	2	8
ITALY	62	38	21	47	168	8	12	5	10	35
JAMAICA	6	0	0	0	6	6	0	0	0	6
JAPAN	17	6	2	2	27	9	4	1	1	15
JORDAN	101	12	3	1	117	70	7	1	1	79
KAZAKHSTAN	24	9	6	14	53	13	3	1	2	19
KENYA	31	9	2	1	43	14	6	1	1	22
KOSOVO	1	1	1	0	3	0	0	1	0	1
KUWAIT	8	1	0	0	9	4	1	0	0	5
KYRGYZSTAN	6	4	0	0	10	3	3	0	0	6
LAOS	1	0	0	0	1	0	0	0	0	0
LATVIA	36	17	5	3	61	16	10	3	2	31
LEBANON	27	8	1	0	36	16	5	1	0	22
LIBYA	32	9	2	3	46	15	6	1	1	23
LITHUANIA	19	8	5	4	36	9	2	3	4	18
MACEDONIA	45	31	24	45	145	10	8	9	10	37
MADAGASCAR	1	0	0	0	1	1	0	0	0	1
MALAWI	2	0	0	0	2	2	0	0	0	2
MALAYSIA	195	45	16	7	263	123	20	7	3	153
MALTA	15	3	0	0	18	11	3	0	0	14
MAURITIUS	7	1	0	0	8	4	1	0	0	5
MEXICO	30	13	4	6	53	8	4	0	2	14
MOLDOVA	6	2	2	3	13	4	0	1	0	5
MONGOLIA	1	1	1	1	4	0	0	0	1	1
MONTENEGRO	1	1	0	0	2	0	0	0	0	0
MOZAMBIQUE	1	0	0	0	1	0	0	0	0	0
MYANMAR	715	151	62	70	998	476	74	21	31	602
NEPAL	160	47	18	8	233	82	22	11	4	119
NETHERLANDS	85	33	15	2	135	44	16	9	1	70
NETHERLANDS ANTILLES	6	1	0	0	7	3	0	0	0	3
NICARAGUA	2	2	1	0	5	0	1	0	0	1
NIGER	1	0	0	0	1	1	0	0	0	1
NIGERIA	317	106	38	43	504	130	55	20	9	214
NORWAY	5	0	0	0	5	4	0	0	0	4
OMAN	13	0	0	0	13	9	0	0	0	9
PAKISTAN	1438	467	185	226	2316	740	215	72	76	1103

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
PALESTINIAN AUTHORITY	3	0	0	0	3	2	0	0	0	2
PAPUA NEW GUINEA	73	42	18	15	148	19	15	9	7	50
PARAGUAY	4	3	0	0	7	2	2	0	0	4
PERU	45	19	8	5	77	18	9	4	3	34
PHILIPPINES	1023	483	252	298	2056	304	153	82	100	639
POLAND	224	118	57	63	462	79	51	26	25	181
PORTUGAL	4	3	2	1	10	2	2	1	0	5
ROMANIA	196	94	52	74	416	82	35	17	18	152
RUSSIA	445	195	95	87	822	162	68	41	24	295
SAINT KITTS AND NEVIS	8	6	2	6	22	2	4	0	2	8
SAINT LUCIA	3	1	0	0	4	2	0	0	0	2
SAMOA	8	3	1	0	12	5	2	0	0	7
SAUDI ARABIA	41	14	6	1	62	16	4	3	1	24
SERBIA	143	84	52	53	332	43	27	22	21	113
SEYCHELLES	3	3	0	0	6	1	2	0	0	3
SINGAPORE	64	16	2	0	82	41	11	2	0	54
SLOVAK REPUBLIC	14	9	2	10	35	4	7	0	0	11
SLOVENIA	2	1	0	0	3	1	1	0	0	2
SOMALIA	5	3	1	2	11	2	2	0	1	5
SOUTH AFRICA	757	125	31	11	924	579	77	21	6	683
SOUTH KOREA	69	18	7	7	101	40	9	2	1	52
SPAIN	21	10	6	14	51	7	3	3	3	16
SRI LANKA	1663	338	100	68	2169	1218	214	50	35	1517
SUDAN	122	43	18	17	200	60	17	8	5	90
SWEDEN	14	3	1	0	18	7	3	1	0	11
SWITZERLAND	29	9	1	0	39	16	6	1	0	23
SYRIA	98	51	31	34	214	41	18	12	13	84
TAIWAN	43	14	7	11	75	19	5	4	1	29
TAJIKISTAN	1	1	0	0	2	0	0	0	0	0
TANZANIA	16	7	1	0	24	3	2	0	0	5
THAILAND	31	8	3	5	47	17	4	1	2	24
TRINIDAD AND TOBAGO	31	5	2	0	38	23	2	2	0	27
TUNISIA	1	0	0	0	1	1	0	0	0	1
TURKEY	72	34	17	16	139	29	14	6	10	59
UGANDA	18	6	0	0	24	8	5	0	0	13
UKRAINE	200	101	47	60	408	75	39	16	18	148
UNITED ARAB EMIRATES	18	7	2	0	27	6	3	2	0	11
UNITED KINGDOM	687	65	11	9	772	591	46	4	5	646
URUGUAY	18	7	2	4	31	8	5	0	2	15
USA	74	11	2	0	87	54	8	1	0	63
USSR	138	83	47	94	362	35	29	9	18	91
UZBEKISTAN	15	5	2	0	22	8	2	2	0	12
VENEZUELA	14	9	3	2	28	3	5	1	2	11
VIET NAM	197	115	57	92	461	68	52	20	21	161
YEMEN	7	0	0	0	7	4	0	0	0	4
ZAMBIA	10	3	0	0	13	6	3	0	0	9
ZIMBABWE	125	21	6	5	157	97	12	3	2	114
Total	20728	6998	2914	3085	33725	11288	3330	1226	1061	16905

Appendix F

MCQ – Country of Training Statistics – All Candidates
01-01-2010 to 31-12-2010

MCQ - Country of Training Statistics - All Candidates

01-01-2010 to 31-12-2010

Generated on 22-01-2011 00:17:00

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
AFGHANISTAN	3	3	3	6	15	0	1	1	1	3
ARGENTINA	0	1	3	3	7	0	0	2	1	3
ARMENIA	2	2	0	0	4	1	2	0	0	3
AUSTRALIA	2	0	0	0	2	1	0	0	0	1
AUSTRIA	4	2	0	0	6	1	0	0	0	1
AZERBAIJAN	0	0	0	2	2	0	0	0	1	1
BALEARIC ISLANDS	1	0	0	0	1	1	0	0	0	1
BANGLADESH	115	51	27	30	223	55	30	7	20	112
BELARUS	3	1	1	0	5	2	0	0	0	2
BELGIUM	3	0	0	0	3	3	0	0	0	3
BOLIVIA	1	0	0	0	1	0	0	0	0	0
BOSNIA-HERZEGOVINA	2	0	0	1	3	2	0	0	1	3
BRAZIL	12	3	4	1	20	9	2	1	0	12
BULGARIA	3	4	2	5	14	2	2	1	2	7
CAMBODIA	2	1	0	0	3	0	1	0	0	1
CANADA	2	0	0	0	2	1	0	0	0	1
CAYMAN ISLANDS	1	0	0	0	1	1	0	0	0	1
CHINA	77	45	17	18	157	36	17	7	5	65
COLOMBIA	13	6	4	1	24	7	5	3	0	15
CROATIA	1	0	0	0	1	1	0	0	0	1
CUBA	0	1	0	0	1	0	0	0	0	0
CZECH REPUBLIC	1	2	1	0	4	1	2	0	0	3
CZECHOSLOVAKIA	0	1	0	0	1	0	1	0	0	1
DENMARK	2	0	0	0	2	2	0	0	0	2
DOMINICA	1	1	0	0	2	1	0	0	0	1
ECUADOR	1	0	0	0	1	0	0	0	0	0
EGYPT	81	22	4	11	118	41	12	2	4	59
EL SALVADOR	1	1	0	0	2	0	1	0	0	1
ESTONIA	0	1	0	0	1	0	1	0	0	1
ETHIOPIA	1	1	0	0	2	0	1	0	0	1
FIJI	14	9	5	4	32	6	4	3	3	16
FRANCE	8	1	2	1	12	6	0	1	1	8
GERMANY	26	4	1	0	31	18	2	0	0	20
GHANA	2	0	0	0	2	2	0	0	0	2
GREECE	3	0	1	3	7	3	0	0	0	3
GUATEMALA	1	0	0	0	1	0	0	0	0	0
GUINEA	1	0	0	0	1	0	0	0	0	0
HONG KONG	2	0	0	0	2	2	0	0	0	2
HUNGARY	4	1	1	2	8	1	0	0	0	1
INDIA	383	146	65	84	678	220	83	30	36	369
INDONESIA	11	6	2	10	29	2	1	0	3	6
IRAN	134	56	17	10	217	84	34	9	5	132
IRAQ	61	15	6	3	85	39	10	5	0	54
IRELAND	7	0	0	0	7	4	0	0	0	4
ISRAEL	1	0	0	0	1	1	0	0	0	1

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
ITALY	3	2	2	8	15	0	0	0	1	1
JAPAN	2	1	1	0	4	1	0	1	0	2
JORDAN	23	3	1	0	27	17	2	0	0	19
KAZAKHSTAN	2	0	1	4	7	1	0	0	1	2
KENYA	7	2	0	0	9	2	2	0	0	4
KYRGYZSTAN	0	1	0	0	1	0	0	0	0	0
LATVIA	3	2	1	3	9	1	1	0	2	4
LEBANON	1	0	0	0	1	0	0	0	0	0
LIBYA	12	3	0	0	15	7	3	0	0	10
LITHUANIA	2	1	1	0	4	2	0	1	0	3
MACEDONIA	1	0	0	0	1	0	0	0	0	0
MALAYSIA	44	10	6	3	63	31	7	3	1	42
MALTA	2	0	0	0	2	1	0	0	0	1
MAURITIUS	4	0	0	0	4	4	0	0	0	4
MEXICO	5	1	0	0	6	1	0	0	0	1
MYANMAR	143	26	10	5	184	92	13	4	2	111
NEPAL	28	11	6	5	50	11	3	3	2	19
NETHERLANDS	5	2	2	0	9	2	0	1	0	3
NIGERIA	64	24	6	12	106	25	17	4	5	51
OMAN	10	0	0	0	10	6	0	0	0	6
PAKISTAN	283	88	31	40	442	152	47	11	16	226
PALESTINIAN AUTHORITY	2	0	0	0	2	1	0	0	0	1
PAPUA NEW GUINEA	8	1	2	3	14	3	0	1	1	5
PARAGUAY	1	0	0	0	1	1	0	0	0	1
PERU	2	0	1	0	3	0	0	0	0	0
PHILIPPINES	110	66	46	71	293	39	17	17	22	95
POLAND	8	1	3	1	13	4	0	1	1	6
ROMANIA	12	7	4	7	30	6	4	2	3	15
RUSSIA	71	29	21	15	136	26	10	10	5	51
SAINT KITTS AND NEVIS	1	0	0	3	4	1	0	0	1	2
SAMOA	2	0	0	0	2	2	0	0	0	2
SAUDI ARABIA	9	5	3	1	18	6	2	0	1	9
SERBIA	2	1	0	2	5	2	1	0	0	3
SEYCHELLES	1	2	0	0	3	0	1	0	0	1
SINGAPORE	4	1	0	0	5	3	1	0	0	4
SLOVAK REPUBLIC	1	0	0	1	2	0	0	0	0	0
SOUTH AFRICA	44	8	5	3	60	34	3	3	2	42
SOUTH KOREA	7	3	2	3	15	5	0	0	1	6
SPAIN	2	0	0	0	2	0	0	0	0	0
SRI LANKA	249	49	11	7	316	197	31	5	4	237
SUDAN	18	4	5	2	29	9	0	1	0	10
SWITZERLAND	4	2	1	0	7	4	1	1	0	6
SYRIA	5	1	3	2	11	5	0	1	1	7
TAIWAN	2	1	0	3	6	1	0	0	0	1
TAJIKISTAN	0	1	0	0	1	0	0	0	0	0
TANZANIA	5	3	1	0	9	1	1	0	0	2
THAILAND	3	1	0	3	7	3	1	0	0	4
TRINIDAD AND TOBAGO	1	1	1	0	3	1	0	1	0	2
TURKEY	4	1	0	0	5	2	0	0	0	2
UGANDA	3	1	0	0	4	2	1	0	0	3

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
UKRAINE	20	20	8	17	65	8	7	1	6	22
UNITED ARAB EMIRATES	4	5	1	0	10	1	3	1	0	5
URUGUAY	0	1	0	0	1	0	1	0	0	1
USSR	1	1	0	3	5	1	1	0	0	2
VENEZUELA	2	1	0	0	3	1	0	0	0	1
VIET NAM	6	2	2	5	15	3	0	1	0	4
YEMEN	2	0	0	0	2	1	0	0	0	1
ZIMBABWE	10	2	0	2	14	10	2	0	2	14
Total	2263	785	354	429	3831	1295	395	146	163	1999

Appendix G

Clinical – Country of Training Statistics – All Candidates
01-01-1978 to 31-12-2010

Clinical - Country of Training Statistics - All Candidates

01-01-1978 to 31-12-2010

Generated on 21-01-2011 17:04:48

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
AFGHANISTAN	72	35	14	8	129	30	17	9	4	60
ALBANIA	3	1	0	0	4	2	1	0	0	3
ALGERIA	5	3	1	0	9	2	2	1	0	5
ARGENTINA	20	7	4	0	31	11	3	3	0	17
AUSTRIA	20	5	1	0	26	13	4	1	0	18
AZERBAIJAN	1	0	0	0	1	1	0	0	0	1
BAHRAIN	1	0	0	0	1	0	0	0	0	0
BANGLADESH	589	251	80	21	941	296	125	40	9	470
BELARUS	18	11	1	0	30	7	6	1	0	14
BELGIUM	13	3	1	0	17	8	2	1	0	11
BOLIVIA	1	0	0	0	1	0	0	0	0	0
BOSNIA-HERZEGOVINA	61	28	8	1	98	31	16	7	1	55
BRAZIL	30	9	1	1	41	18	6	0	0	24
BULGARIA	41	18	6	0	65	21	10	4	0	35
CAMBODIA	7	4	3	2	16	2	1	1	0	4
CAMEROON	1	0	0	0	1	1	0	0	0	1
CANADA	43	10	2	1	56	26	7	1	1	35
CHILE	11	3	1	0	15	9	2	1	0	12
CHINA	572	190	64	17	843	351	109	41	16	517
COLOMBIA	42	8	2	0	52	31	6	2	0	39
CROATIA	40	21	9	7	77	15	12	4	4	35
CUBA	1	0	0	0	1	1	0	0	0	1
CZECH REPUBLIC	13	5	1	0	19	8	4	1	0	13
CZECHOSLOVAKIA	33	20	9	7	69	13	10	5	3	31
DEMOCRATIC REPUBLIC OF THE CONGO	2	1	0	0	3	1	0	0	0	1
DENMARK	10	1	0	0	11	9	1	0	0	10
DOMINICAN REPUBLIC	4	2	1	1	8	0	1	0	1	2
ECUADOR	6	1	0	0	7	4	1	0	0	5
EGYPT	596	315	153	166	1230	258	143	64	76	541
EL SALVADOR	5	1	1	0	7	2	0	1	0	3
ETHIOPIA	16	6	1	0	23	8	5	1	0	14
FIJI	106	34	10	3	153	65	18	7	2	92
FINLAND	5	2	0	0	7	2	1	0	0	3
FRANCE	13	4	0	0	17	8	3	0	0	11
GEORGIA	1	0	0	0	1	1	0	0	0	1
GERMANY	213	57	16	10	296	142	31	10	3	186
GHANA	5	1	1	1	8	4	0	0	1	5
GREECE	15	6	2	4	27	5	3	1	0	9
GRENADA	5	1	0	0	6	4	1	0	0	5
GUATEMALA	3	3	3	2	11	0	0	1	0	1
GUYANA	1	0	0	0	1	1	0	0	0	1
HONG KONG	163	43	9	2	217	96	28	6	1	131
HUNGARY	44	19	6	1	70	24	9	5	1	39
ICELAND	1	1	0	0	2	0	0	0	0	0
INDIA	1915	624	201	130	2870	1091	342	106	61	1600

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
INDONESIA	41	21	11	1	74	15	8	7	1	31
IRAN	368	100	15	1	484	236	64	13	1	314
IRAQ	420	158	38	7	623	238	103	24	6	371
IRELAND	95	15	1	0	111	74	11	1	0	86
ISRAEL	7	1	1	0	9	6	0	1	0	7
ITALY	27	15	7	12	61	10	8	1	4	23
JAMAICA	5	1	0	0	6	3	1	0	0	4
JAPAN	6	2	0	0	8	2	2	0	0	4
JORDAN	18	5	1	0	24	9	3	1	0	13
KAZAKHSTAN	12	2	2	0	16	9	0	1	0	10
KENYA	13	2	1	0	16	10	1	1	0	12
KOSOVO	1	1	1	0	3	0	0	1	0	1
KUWAIT	3	2	1	1	7	0	1	0	1	2
KYRGYZSTAN	2	1	0	0	3	1	1	0	0	2
LATVIA	19	1	0	0	20	14	1	0	0	15
LEBANON	16	6	4	2	28	7	1	2	2	12
LIBYA	7	4	2	0	13	3	2	2	0	7
LITHUANIA	13	7	1	0	21	5	5	1	0	11
MACEDONIA	30	15	6	1	52	12	4	5	1	22
MADAGASCAR	1	0	0	0	1	1	0	0	0	1
MALAWI	2	0	0	0	2	1	0	0	0	1
MALAYSIA	54	16	0	0	70	29	12	0	0	41
MALTA	9	3	2	0	14	6	1	2	0	9
MAURITIUS	1	0	0	0	1	0	0	0	0	0
MEXICO	9	2	0	0	11	5	2	0	0	7
MOLDOVA	4	1	0	0	5	3	0	0	0	3
MYANMAR	280	98	42	26	446	158	45	19	9	231
NEPAL	52	9	2	0	63	36	5	2	0	43
NETHERLANDS	47	11	4	0	62	32	6	2	0	40
NETHERLANDS ANTILLES	1	0	0	0	1	1	0	0	0	1
NICARAGUA	1	0	0	0	1	1	0	0	0	1
NIGER	1	0	0	0	1	1	0	0	0	1
NIGERIA	91	24	1	1	117	53	16	0	1	70
NORWAY	3	3	0	0	6	0	3	0	0	3
OMAN	1	0	0	0	1	0	0	0	0	0
PAKISTAN	513	178	38	13	742	284	101	21	8	414
PALESTINIAN AUTHORITY	1	0	0	0	1	1	0	0	0	1
PAPUA NEW GUINEA	37	16	5	3	61	17	5	1	2	25
PERU	18	6	2	3	29	7	3	0	1	11
PHILIPPINES	373	182	70	64	689	137	78	28	17	260
POLAND	149	79	32	26	286	65	41	15	12	133
PORTUGAL	3	1	1	0	5	1	0	1	0	2
ROMANIA	113	51	24	17	205	57	20	11	7	95
RUSSIA	171	59	17	2	249	100	34	14	0	148
SAINT KITTS AND NEVIS	3	1	1	0	5	2	0	1	0	3
SAINT LUCIA	2	0	0	0	2	2	0	0	0	2
SAMOA	1	0	0	0	1	1	0	0	0	1
SAUDI ARABIA	1	0	0	0	1	0	0	0	0	0
SERBIA	90	44	16	4	154	42	23	10	3	78
SINGAPORE	38	9	3	0	50	26	6	3	0	35
SLOVAK REPUBLIC	10	4	0	0	14	6	3	0	0	9

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
SLOVENIA	2	1	1	0	4	1	0	1	0	2
SOMALIA	4	2	2	1	9	1	0	1	0	2
SOUTH AFRICA	474	69	11	10	564	383	52	4	5	444
SOUTH KOREA	23	13	5	7	48	8	4	2	1	15
SPAIN	13	6	5	5	29	6	1	2	0	9
SRI LANKA	813	271	79	57	1220	472	170	43	23	708
SUDAN	51	17	6	0	74	32	7	5	0	44
SWEDEN	6	2	1	0	9	2	1	0	0	3
SWITZERLAND	12	4	2	0	18	8	2	1	0	11
SYRIA	60	29	17	9	115	31	10	9	3	53
TAIWAN	20	5	1	1	27	9	3	0	1	13
TANZANIA	2	0	0	0	2	2	0	0	0	2
THAILAND	13	5	1	1	20	5	3	0	0	8
TRINIDAD AND TOBAGO	21	1	0	0	22	16	0	0	0	16
TUNISIA	1	1	0	0	2	0	1	0	0	1
TURKEY	52	19	7	9	87	28	10	4	3	45
UGANDA	9	3	1	0	13	6	1	1	0	8
UKRAINE	84	25	5	0	114	45	18	5	0	68
UNITED ARAB EMIRATES	3	1	0	0	4	2	1	0	0	3
UNITED KINGDOM	479	55	5	0	539	401	48	5	0	454
URUGUAY	12	4	3	0	19	8	1	3	0	12
USA	52	18	1	0	71	28	15	1	0	44
USSR	82	41	19	5	147	35	18	9	4	66
UZBEKISTAN	10	4	0	0	14	5	3	0	0	8
VENEZUELA	7	3	0	0	10	4	2	0	0	6
VIET NAM	130	81	36	52	299	41	37	11	15	104
YEMEN	1	0	0	0	1	1	0	0	0	1
ZAMBIA	7	3	1	0	11	4	2	1	0	7
ZIMBABWE	69	8	1	0	78	54	6	1	0	61
Total	10462	3601	1174	726	15963	5989	1966	625	315	8895

Appendix H

Clinical – Country of Training Statistics – All Candidates
01-01-2010 to 31-12-2010

Clinical - Country of Training Statistics - All Candidates

01-01-2010 to 31-12-2010

Generated on 21-01-2011 17:06:25

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
AFGHANISTAN	5	2	0	0	7	1	1	0	0	2
ALGERIA	0	0	1	0	1	0	0	1	0	1
ARGENTINA	2	0	1	0	3	1	0	0	0	1
AUSTRIA	6	0	0	0	6	5	0	0	0	5
BAHRAIN	1	0	0	0	1	0	0	0	0	0
BANGLADESH	46	24	19	3	92	23	10	11	0	44
BELARUS	1	1	0	0	2	1	1	0	0	2
BELGIUM	2	0	0	0	2	2	0	0	0	2
BOSNIA-HERZEGOVINA	1	1	0	0	2	1	0	0	0	1
BRAZIL	8	4	0	0	12	5	3	0	0	8
BULGARIA	4	1	0	0	5	3	1	0	0	4
CHINA	65	12	4	1	82	46	5	2	1	54
COLOMBIA	6	2	0	0	8	4	2	0	0	6
CROATIA	0	0	1	0	1	0	0	0	0	0
DENMARK	1	0	0	0	1	1	0	0	0	1
DOMINICAN REPUBLIC	2	0	0	0	2	0	0	0	0	0
EGYPT	27	4	3	0	34	23	4	2	0	29
EL SALVADOR	1	0	1	0	2	0	0	1	0	1
ETHIOPIA	2	0	0	0	2	1	0	0	0	1
FIJI	14	5	0	0	19	7	2	0	0	9
GERMANY	18	6	1	0	25	15	2	1	0	18
GREECE	1	0	0	0	1	1	0	0	0	1
GUATEMALA	0	0	1	0	1	0	0	0	0	0
GUYANA	1	0	0	0	1	1	0	0	0	1
HUNGARY	2	4	0	0	6	0	1	0	0	1
INDIA	273	70	13	2	358	178	42	7	2	229
INDONESIA	5	1	2	0	8	1	0	0	0	1
IRAN	70	32	6	0	108	41	16	5	0	62
IRAQ	31	4	5	0	40	15	2	3	0	20
IRELAND	4	0	0	0	4	3	0	0	0	3
ISRAEL	1	0	0	0	1	1	0	0	0	1
ITALY	0	0	1	0	1	0	0	1	0	1
JAPAN	2	0	0	0	2	1	0	0	0	1
JORDAN	4	1	0	0	5	2	0	0	0	2
KAZAKHSTAN	1	0	0	0	1	1	0	0	0	1
KENYA	3	1	0	0	4	1	1	0	0	2
LATVIA	7	1	0	0	8	3	1	0	0	4
LEBANON	1	0	0	0	1	0	0	0	0	0
LITHUANIA	1	0	0	0	1	0	0	0	0	0
MACEDONIA	2	1	0	0	3	0	0	0	0	0
MALAYSIA	7	1	0	0	8	6	1	0	0	7
MALTA	2	0	0	0	2	2	0	0	0	2
MAURITIUS	1	0	0	0	1	0	0	0	0	0
MYANMAR	55	8	8	1	72	41	5	6	1	53
NEPAL	13	3	1	0	17	5	2	1	0	8
NETHERLANDS	8	0	0	0	8	7	0	0	0	7

Country Trained	Sat 1	Sat 2	Sat 3	Sat 4	Sat Total	Pass 1	Pass 2	Pass 3	Pass 4	Pass Total
NIGER	1	0	0	0	1	1	0	0	0	1
NIGERIA	17	3	0	0	20	10	0	0	0	10
OMAN	1	0	0	0	1	0	0	0	0	0
PAKISTAN	98	39	9	2	148	57	20	6	1	84
PAPUA NEW GUINEA	4	1	0	0	5	0	0	0	0	0
PERU	4	1	0	0	5	0	0	0	0	0
PHILIPPINES	60	28	8	1	97	27	13	3	0	43
POLAND	3	0	1	0	4	3	0	1	0	4
ROMANIA	3	2	0	0	5	2	1	0	0	3
RUSSIA	21	10	2	0	33	13	7	1	0	21
SAINT KITTS AND NEVIS	1	0	1	0	2	1	0	1	0	2
SAINT LUCIA	1	0	0	0	1	1	0	0	0	1
SAUDI ARABIA	1	0	0	0	1	0	0	0	0	0
SERBIA	4	1	1	0	6	3	0	0	0	3
SINGAPORE	1	0	0	0	1	1	0	0	0	1
SLOVAK REPUBLIC	1	0	0	0	1	1	0	0	0	1
SOUTH AFRICA	65	5	0	0	70	57	3	0	0	60
SOUTH KOREA	2	2	0	0	4	1	1	0	0	2
SRI LANKA	118	27	2	0	147	88	18	2	0	108
SUDAN	3	0	4	0	7	1	0	3	0	4
SYRIA	4	1	0	0	5	3	0	0	0	3
TAIWAN	3	0	0	0	3	1	0	0	0	1
THAILAND	2	0	0	0	2	1	0	0	0	1
TRINIDAD AND TOBAGO	10	0	0	0	10	9	0	0	0	9
TURKEY	5	0	0	0	5	3	0	0	0	3
UGANDA	0	1	0	0	1	0	1	0	0	1
UKRAINE	11	2	2	0	15	4	1	2	0	7
UNITED ARAB EMIRATES	1	1	0	0	2	1	1	0	0	2
USA	1	0	0	0	1	1	0	0	0	1
USSR	3	1	0	0	4	0	0	0	0	0
UZBEKISTAN	0	1	0	0	1	0	0	0	0	0
VENEZUELA	0	1	0	0	1	0	0	0	0	0
VIET NAM	5	0	0	0	5	1	0	0	0	1
ZIMBABWE	10	1	0	0	11	7	1	0	0	8
Total	1171	317	98	10	1596	747	169	60	5	981

Appendix I

Specialist Assessment Process by Medical Specialty
01-01-2010 to 31-12-2010

Specialist Assessment Process by Medical Specialty

Date Range from: 01-01-2010 to 31-12-2010

Generated on 22-01-2011 00:12:01

Assessment Process / Medical Specialty	Initial Processing	Approved	Not Comparable	Further Training and/or Examinations	Application Lapsed	Withdrawn	Grand Total
Adult Medicine	94	89	9	21	0	8	221
Anaesthesia	41	38	9	48	0	9	145
Dermatology	7	3	3	3	0	0	16
Emergency Medicine	17	13	0	10	0	2	42
General Practice	185	7	0	11	0	9	212
Intensive Care	6	2	1	7	0	4	20
Medical Administration	0	0	0	1	0	0	1
Obstetrics and Gynaecology	46	46	13	10	1	2	118
Occupational and Environmental Medicine	1	0	0	0	0	0	1
Ophthalmology	20	5	2	12	0	1	40
Oral and Maxillofacial Surgery	2	0	0	1	0	1	4
Paediatrics and Child Health	48	36	11	15	0	4	114
Pain Medicine	1	0	0	0	0	0	1
Palliative Medicine	0	1	0	1	0	0	2
Pathology	33	19	0	24	0	4	80
Psychiatry	40	47	1	42	0	2	132
Public Health Medicine	6	0	0	0	0	0	6
Radiology	25	40	0	43	0	5	113
Rehabilitation Medicine	4	1	1	1	0	1	8
Sexual Health Medicine	1	0	0	0	0	0	1
Surgery	78	61	25	43	0	49	256
	655	408	75	293	1	101	1533

Appendix J

Clinical Applications by Series
2009/2010

CLINICAL APPLICATIONS

2009/2010	NUMBER OF APPLICATIONS FOR SERIES	First Attempts	Repeat Attempts	NUMBER OF POSITIONS OFFERED FOR FIRST ATTEMPT	NUMBER OF POSITIONS OFFERED FOR REPEAT ATTEMPT	TOTAL CANDIDATES SCHEDULED	NUMBER OF WAITING LIST POSITIONS OFFERED	EXAMINATION NO.	ACTUAL
SERIES 1	1206	943	263	224	105	329	300	09/10 01B	70
								09/10 02M	71
								09/10-03S	70
								09/10-04A	72
								09/10-14S	18
SERIES 2	1599	1274	325	240	73	324	300	09/10-05B	72
								09/10-06P	35
								09/10-07M	71
								09/10-08M	70
								09/10-09S	71
SERIES 3	1716	1395	321	336	96	432	300	09/10-10M	72
								09/10-11S	68
								09/10-12B	71
								09/10-13A	71
								09/10-15M	72
								09/10-16S	71
SERIES 4	1494	1205	289	144	72	216	160	09/10-17B	72
								09/10-18A	70
								09/10-19P	71
TOTAL MAIN EXAMINATIONS	6015	4817	1198	944	346	1301	1060		1258
RETEST SERIES								09/10 R1M	60
								09/10 R2M	60
								09/10 R3S	59
								09/10 R4M	119
TOTAL RETEST									298
TOTAL CANDIDATES 2009/2010									1556

Appendix K

Joint AMC/CPMC Standing Committee on Overseas Trained Specialists (JSCOTS) – Assessment of Overseas Trained Specialists Guidance for Colleges

JOINT AMC/CPMC STANDING COMMITTEE ON OVERSEAS TRAINED SPECIALISTS (JSCOTS)

ASSESSMENT OF OVERSEAS TRAINED SPECIALISTS

GUIDANCE FOR COLLEGES

PURPOSE

This document recognises and accepts that specialist colleges in Australia determine professional standards in their discipline. JSCOTS recognises that individual College requirements for assessment and training of overseas trained specialists may vary.

It is intended to assist colleges to meet their legal responsibilities to third parties such as patients who may subsequently be treated by the International Medical Graduate (IMG), employers of the specialist and the specialist himself or herself.

In writing this guidance information has been drawn from the ACCC's 2003 final determination on the application for authorisation in relation to the selection, training and examination processes of the Royal Australasian College of Surgeons.

Colleges should facilitate easy access to clear documentation regarding OTS specialist assessment including: the requirements to be met and the reasons why they are imposed; the steps in the assessment process; the meaning of key terms in the Australian context; the standards and criteria that will be used to assess the applicant; the possible outcomes of assessment; and information about how to access appeals processes.

INTRODUCTION

Colleges advise medical registration authorities, through the Australian Medical Council, on the suitability for registration as a specialist in Australia of international medical graduates who hold a specialist qualification obtained overseas.[1] This process entails an assessment by the college to determine if the training and experience of the international medical graduate is substantially comparable, partially comparable or not comparable to that of an Australian-trained specialist. This assessment activity is an important service for the Australian community in ensuring that the standards of its medical services are maintained.

This guidance document addresses the procedures for assessing applicants.[2] This document takes account of the Australian Medical Council's experience in the accreditation of the colleges' specialist medical education and training programs, including the colleges' processes for assessing the training and experience of international medical graduates.

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[1] This statement is not absolute, exceptions include where applicants obtain qualifications in an AMC accredited medical school in an overseas location.

[2] The original guidance was produced in 2002 by the Chair of JSCOTS (Professor Peter Phelan), and amended in 2003 with advice from the Committee of Presidents of Medical Colleges' solicitors.

COMMUNICATION WITH THE APPLICANTS

In general all college communications with applicants should be via the AMC except for giving dates of interviews or components of the assessment.

DOCUMENTING CRITERIA FOR ASSESSMENT AND PROCEDURES FOR ASSESSMENT

A college requiring information from applicants over and above the documentation requirements specified in the AMC's ***Information Booklet for Applicants – Application Procedures and Requirements for Specialist Assessment*** should provide the AMC with a leaflet specifying the college's requirements. The AMC will send this to applicants, together with the relevant Application Forms, ***Information Booklet for Applicants*** and other material.

Each college should develop criteria for an initial assessment, which should be used to assess the applicant on the basis that his or her training and experience are: substantially comparable, partially comparable or not comparable to an Australian trained specialist.

Assessment will usually involve an initial paper based assessment and a subsequent interview unless the applicant is assessed as "non-comparable" when there is not a requirement to hold an interview.

Substantially comparable *applicants should be permitted conditional registration* to undertake the intended scope of practice independently and unsupervised. In order to be considered substantially comparable an applicant must have satisfied the college requirements for this category in relation to previous training, assessment and recent practice. The applicant is eligible for registration as a recognised specialist and may apply for fellowship without further examination, but may be required to undertake a period of up to 12 months oversight or practice under peer review by a reviewer appointed through the college assessment unit. This is to ensure that the level of performance is similar to that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access continuing professional development. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis.*

Partially comparable *applicants should be permitted conditional registration to undertake a defined scope of practice in a supervised capacity. In order to be considered partially comparable an applicant must have satisfied the college requirements for this category in relation to previous training, assessment and recent practice. In order for a partially comparable applicant to be considered substantially comparable the applicant will be required to undertake a period of up to 24 months of training and assessment under a supervisor appointed through the college assessment unit, to ensure that the level of performance reaches that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access continuing professional development. Other prescribed requirements including formal assessment may be imposed.*

Non-comparable *applicants should not be permitted to register to practices as a specialist, but may be eligible to seek registration to practices in another capacity (e.g. as hospital medical officers) to enable them to gain the AMC certificate, and subsequently undertake formal college training and assessment, if able to gain a training post subject to other college requirements.*

* The type of specialist registration granted will be in accordance with the Medical Board of Australia after July 1 2010.

IMPORTANT NOTE: The above definitions are based upon the current *Guidelines on the Specialist Assessment Pathways,* document endorsed by the COAG IMG Technical Committee on 10 June 2008. The definitions for Substantial Comparability / Partial Comparability and Non-comparability are taken directly from the ACCC final report on the application for authorization by the Royal Australasian College of Surgeons. The RACS authorisation was later extended to all other specialist colleges.

Wherever possible, the criteria used to assess overseas trained specialists should be consistent with criteria the college uses for its own trainees. The criteria or statement of process, used by the college to assess international medical graduates should be made publicly available by the college.

The procedures must be demonstrably fair and meet the requirements of equity and natural justice. It is essential that the college follows these procedures. If there is any deviation from them, the reasons for this must be documented and the college must be confident the deviation can be justified if legally challenged.

Having developed the criteria, each college should ensure that its processes use only those criteria and do not stray into irrelevant areas or use irrelevant information.

ESTABLISHING A COMMITTEE TO BE RESPONSIBLE FOR ASSESSMENTS

Colleges should have an established committee, sub-committee or board responsible for undertaking assessments. Its members should have knowledge of and expertise in the assessment of local trainees.

The college committee should comprise a reasonable number of fellows. The college committee should include at least one fellow who has completed their specialist training overseas and has been previously assessed by the college through the specialist assessment pathway. Community representation should be considered. The operations of the college committee should be covered by conflict of interest policies.

Members of the college committee and any associated assessment panel(s) should be supported by appropriate training and by a clear statement of policy and procedures that govern their decision-making processes.

Assessors of an individual applicant should not have taken part in any substantive decision affecting that individual, or have any relationship with the individual (whether family, financial, or otherwise), which would preclude them from dealing with the matter openly or fairly.

DOCUMENTATION OF ASSESSMENT PROCESS

It is imperative that the college keeps full and accurate documentation of each stage of the assessment process recognising that this may be subpoenaed in a court of law. It should avoid subjective and anecdotal comments.

Only documentation which is relevant to the process should be used. The college committee is not bound by formal legal rules of evidence, unlike Courts. However

the college committee should avoid placing any or too much weight on information from anonymous parties, or information which is second or third hand. Opinions should be regarded merely as such, unless the person providing the opinion is entirely qualified to have their opinion respected.

EVIDENCE USED FOR ASSESSMENT

In making its assessment, the college should only use forms of evidence which it has publicly documented that it will use. The assessment standards and criteria should be documented in a format that can be clearly understood and should be publicly available, for example, information placed on the college's website.

As noted, the college committees are not bound by formal legal rules of evidence. However, evidence used for the assessment must only be that which is relevant to the criteria. If there is information adverse to the applicant, the applicant must be advised of the material, the applicant will be entitled to make submissions in relation to that material, and the applicant must have adequate opportunity to do so. In some circumstances, it may be necessary for the applicant to present his or her submissions personally.

DOCUMENTATION PROVIDED BY THE APPLICANT

The AMC requires the applicant to lodge documents relating to their undergraduate education and postgraduate training and qualifications. The college should review what the AMC requires. If the college needs additional material the college may request the documentation from the applicant.

Since 1 January 2006, all applications for assessment through the AMC specialist college pathway require primary source verification of qualifications. This is undertaken by the International Credentials Service of the Education Commission for Foreign Medical Graduates (ECFMG) of the United States.

ACTION TO BE TAKEN BY COLLEGE ON RECEIPT OF APPLICATION

The college should notify the applicant of the receipt of the application and indicate when it will next communicate with the applicant concerning the assessment procedures.

There should be college procedures to check promptly that all documentation required by the college has been provided and also to make a decision about whether the applicant will be interviewed. This decision should be communicated to the applicant together with the date, time and place of interview and the issues to be covered at interview.

If the assessment of the documentation is that the college determines the applicant is *non comparable* then there is no requirement to hold an interview.

In all other circumstances, the college would be wise to interview the applicant.

Note, again, that where the college committee obtains information from other sources which may be adverse or critical of the applicant, that information should be given to the applicant, and the applicant should have an opportunity to respond and make submissions on it.

Where practicable, ***Report 1*** (initial assessment) should be made available to the AMC within three months of receipt by the college of the complete application for assessment.

THE INTERVIEW

The interview should be undertaken by trained assessors who have been delegated by the college committee to undertake the assessment for a decision to be made.

The aim of the interview should be to confirm details of the training and experience provided in the written documentation. Past experience has indicated that relying on written documentation alone can be unreliable.

Questions raised in the interview should be formalised as much as possible, and questions irrelevant to the assessment criteria should be avoided.

Following the interview, ***Report 1*** is completed and forwarded to the AMC.

PROCEDURAL FAIRNESS

The college committee will be subject to legal rules and principles, including the application of the rules of 'natural justice', or 'procedural fairness'. These require:

- The applicant should have adequate notice of any hearing, interview or submission required in order for them to have adequate opportunity to put their views.
- If there is material adverse to or critical of the applicant, the applicant must be advised of the material and given adequate opportunity to respond and make submissions.
- Decisions made in relation to applicants should be consistent with the defined process and applied criteria.
- Committees should not consider material which is not relevant to the criteria as set.
- The college committee should be free of bias or prejudice.

Normally, in relation to these proceedings, parties directly involved will not be subject to the ordinary laws relating to defamation. The protection of "qualified privilege" will apply to such proceedings. However, statements made by individuals which go beyond what is strictly necessary for the proceedings, or assessment, may lose protection from defamation, particularly if it is mischievous or malicious. Whilst there is some protection from defamation involved in these proceedings, college committee members should deal only with the relevant matters and not stray into character issues or clearly irrelevant material.

FURTHER ASSESSMENTS

At the end of the interview, the college will decide what further assessments are required such as supervised clinical practice for up to 2 years in specified areas of clinical experience and/or an examination. These requirements must be in line with the assessment procedures as described by the college in documentation provided to the AMC and prospective applicants, and must be detailed in ***Report 1***.

If the college has specific requirements for prospective approval of posts or supervisors these must be communicated to the applicant, preferably via the AMC. Similarly it should inform the nominated supervisor of the reports it requires and their timing.

The college has no responsibility for finding the applicant a suitable post. It should nominate an appropriate person who could give general advice and assistance to the applicant about the type of posts that would be suitable and where they may be available. Wherever possible, the supervised clinical practice and specified clinical experience should parallel that required of local trainees to the standard expected at the completion of their training. The college should not require an applicant to complete supervised clinical practice or specific clinical experience that in principle could not be obtained by a local trainee.

Reasons for requiring specific areas of experience should be clearly documented.

Wherever possible, to maintain face validity, any examination should use the format of that used for local trainees. The standard of assessments required must be clearly enunciated to both applicant and examiners.

If further training and assessment is required all assessments should be completed within 24 months of commencing practice in a supervised position. It is important to acknowledge however that difficulties may arise in obtaining outcomes of required further assessment within the specific two year time period. In these circumstances, although the requirement is not expected to be open-ended, colleges are able to apply a flexible approach in considering outcomes of further assessment received after the two year period expires. An important consideration for the two year time period is the amount of time lapsed between the specialist assessment undertaken by the college, and the commencement of practice in the supervised position. Time lines should be established to enable applicants to complete assessment requirements in a manner that affords them fairness and equity relative to local trainees.

At the completion of the further assessments, a ***Report 2*** is completed and forwarded to the AMC.

REPORTING THE OUTCOME OF A SPECIALIST ASSESSMENT

JSCOTS has developed standardised reporting forms for colleges to complete after an outcome has been determined in accordance with its specialist assessment processes. These have been modified in light of discussions with specialist colleges.

Depending upon the outcome of the specialist assessment, colleges will advise the AMC of the assessment outcome via a Report 1 or Report 2. Upon receiving either the Report 1 or Report 2, the AMC will provide a copy of the Report and advise the medical board in accordance with the procedures set out in the AMC's ***Information Booklet for Applicants – Application Procedures and Requirements for Specialist Assessment.***

Combined Area of Need/Specialist Assessment Reports

For those colleges that are in a position to undertake concurrent AON/specialist assessments, the AMC has provided a standard combined AON/Specialist Assessment Report. The combined Report contains the same information as the standard Report 1 and Report 2 for specialist assessment but also combines a pro forma outcome in relation to the AON assessment completed by the college.

The combined Report provides a mechanism for colleges to send to the AMC one document reporting the outcome of the AON and specialist assessment completed for each IMG.

For those colleges that are not in a position to undertake concurrent AON/Specialist assessments or for individual assessments that are completed for specialist assessment for comparability only, the standard Report 1 and Report 2 can be used as described below.

Substantially Comparable Outcome (initial assessment) – Report 1

If a college determines an applicant to be 'substantially comparable' to the standard of an Australian trained specialist, the college should provide a Report 1 to the AMC advising of the assessment outcome accordingly. The AMC will then notify the medical board of the applicant's eligibility to seek conditional registration to practise in the assessed specialty only.

A period of up to 12 months oversight or orientation can be required before an applicant can be deemed eligible to apply for specialist registration. The oversight is not intended to be a formal or full assessment of the individual overseas trained specialist as it is expected that any such assessment will have been undertaken in determining the 'substantial comparability'. The oversight would normally involve a peer review or similar evaluation to establish that an overseas trained specialist, who has never worked within the Australian health care system, is able to function effectively as a specialist within the relevant field of specialist practice. If after a period of oversight the candidate is no longer assessed as 'substantially comparable' he/she will be deemed to be partially comparable and required to successfully complete the requirements as if initially assessed as partially comparable before being eligible for specialist registration.

Partially Comparable Outcome (initial assessment) – Report 1

If a college determines an applicant to be 'partially comparable' to the standard of an Australian trained specialist, it should request the applicant complete a period of up to 24 months of training and assessment as decided by the college and/or examination before the college completes the final assessment **(and communicates the outcome by completion of a Report 2)**. The AMC will notify the medical board of the outcome of the assessment and will request the applicant to confirm that he or she will (or will not) comply with the college requirements as set out in the Report 1.

Not Comparable Outcome (initial assessment) – Report 1

If a college determines an applicant to be 'not comparable' to the standard of an Australian trained specialist, the college must advise the AMC accordingly via a Report 1. The college is only required to advise the AMC of the outcome through the standardised Report 1. It is the responsibility of the assessing college to ensure that it has sufficient documentation to justify why a 'not comparable' determination was reached. The AMC will notify the applicant of the outcome of the college assessment and advise the applicant that they may be eligible to apply under an AMC non-specialist pathway to obtain general registration to practise in Australia.

To be eligible to access specialist medical training in Australia, applicants must have completed an AMC accredited basic medical degree in Australia of New Zealand or successfully completed an AMC non-specialist pathway for international medical graduates. Information on AMC non-specialist pathways is available at www.amc.org.au.

Upon completion of the requirements of the AMC non-specialist pathway, an applicant may then be eligible to seek entry into a college training program in the relevant specialty. Some colleges may require additional eligibility criteria to be met before an applicant can seek entry into a college training program. Colleges should ensure that information on college training programs is readily accessible (for example, made available on the college website) to all interested parties.

Partially Comparable Outcome Completed – Report 2 (final assessment)

The Report 2 acknowledges the period of supervision and/or examination previously specified by the college and requests confirmation that the supervision requirement has been completed by the applicant. The college is required to notify the AMC, by way of a yes or no answer, whether the college recommends that the applicant be granted recognition as a specialist (the outcome of the final assessment).

If the Report 2 outcome is yes, the AMC will then notify the medical board of the applicant's eligibility to present to the medical board seeking conditional registration to practise in the assessed specialty only.

If the Report 2 outcome is no, the AMC will notify the applicant of the outcome of the college assessment and advise the applicant that they may be eligible to apply under an AMC non-specialist pathway to obtain general registration to practise in Australia.

The college should determine how best to ensure appropriate jurisdictional input into decision-making in relation to the assessment of applicants.

It is expected that applicants who have been determined to be partially comparable will demonstrate progress towards meeting requirements for further assessment. Achieving partial comparability is not an end point in the specialist assessment process.

CONTINUING PROFESSIONAL DEVELOPMENT

AMC standards for accreditation require that colleges have mechanisms to allow doctors who are not fellows to access relevant continuing professional development and other educational opportunities.

FELLOWSHIP REQUIREMENTS

For applicants judged substantially comparable, colleges should provide a fair and efficient process to apply for fellowship of the college. It is expected that the applicant will not be required to complete a formal examination prior to being eligible to apply for fellowship if they have been determined to be substantially comparable by the college.

A period of up to 12 months oversight or orientation can be required before an applicant can be deemed eligible to apply for fellowship. The oversight is not intended to be a formal or full assessment of the individual overseas trained specialist and may be concurrent with the period of provisional registration. It is expected that any such assessment will have been undertaken in determining the substantial comparability. The oversight would normally involve a peer review or similar evaluation to establish that an overseas trained specialist, who has never worked within the Australian health care system, is able to function effectively as a specialist within the relevant field of specialist practice. If after a period of oversight the candidate is no longer assessed as substantially comparable he/she will be deemed to be partially comparable and required to successfully complete the requirements as if initially assessed as partially comparable before being eligible for specialist registration and applying for Fellowship.

If it is determined that the specialist concerned requires further formal assessment before substantial comparability can be confirmed, the outcome of the assessment should be partially comparable not substantially comparable with oversight.

Colleges should provide clear and publicly available documentation on any applications or processes which applicants must complete to seek fellowship after being considered substantially comparable.

APPEALS PROCESS

The applicant should be made aware of the college's AMC accredited appeals process.

COMMON ASSESSMENT CRITERIA

It is recognised that a number of common criteria may be relevant, across all specialties, to the assessment of specialist skills and training of international medical graduates by specialist colleges in Australia.

Attachment A to this Guidance document sets out a number of common domains of specialist practice that may form criteria applicable to the assessment of an international medical graduate considering applying under the specialist assessment pathway in Australia. It is noted that specific criteria are applied by specialist colleges according to the relevant specialty, and the list at Attachment A is intended to be used as a general guide only.

ATTACHMENT A
Common Criteria in Specialist Assessment Process – Information for Overseas Trained Specialists

Overseas Trained Specialists are advised that the following criteria have been set out to identify common criteria that are taken into account by specialist colleges in undertaking specialist assessments, in addition to specific college criteria as applicable in each relevant specialty.

Education/Training
Is your specialist training comparable with the College's vocational training program with regards to:

- Duration
- Structure
- Content
- Curriculum
- Sub-specialty experience
- Supervision
- Assessment including examinations
- Entry requirements
- Course accreditation

Obtained Specialist Qualifications
Can you provide original or certified documentation demonstrating your:

- Specialist qualifications obtained
- Medical registration
- Eligibility for specialist practice (demonstrated through a C.V. with witnesses capable of confirming the information.)

Clinical Experience
Can you demonstrate that the quality, quantity and scope of your specialist experience through the following criteria:

- Variety of case mix
- Details of practice
- Use of equipment and drugs
- Patient management
- Compliance with standards of competence and safety expected of Australian trained specialist
- Evidence of recent practice, demonstrated by valid certificate(s) of good standing and/or log book records

Participation in continuing education/quality assurance activities
Can you demonstrate your involvement through relevant original or certified documentation:

- Participation in continuing education, comparable to the College's Maintenance of Professional Standards Program (MOPS).
- Continuous involvement in recent years is particularly important

Seven key roles of a specialist

It is important that medical practitioners are aware of, and where appropriate demonstrate, knowledge and understanding of the seven key roles of a specialist. These roles are not assessed as part of the AMC specialist pathway; however specialist practitioners in Australia are expected to abide by them during practice, including while under oversight or supervision. If the applicant shows deficiency in any of these areas they are given the opportunity to correct deficiencies and may be required to complete further assessment to demonstrate improvement. In Australia, the key roles of a medical specialist includes the following:

- ***Medical Expert / Clinical Decision maker*** - To be knowledgeable about and able to perform operations and tasks at a level equivalent to an Australian trained specialist. This role is assessed through a combination of the applicants training and experience.
- ***Communicator*** – To be able to clearly, considerately and sensitively communicate with patients, carers, other health professionals and members of the general public in a variety of settings.
- ***Collaborator*** – To be able to collaborate effectively with people experiencing specialty related problems, carers, other health professionals and members of the general public in a variety of settings.
- ***Manager*** – To be knowledgeable about the organisation and delivery of specialist health care including the ethical, economic, geographical and political constraints within which it is delivered. To be able to "manage" effectively in a health setting and the community.
- ***Health Advocate*** – To be knowledgeable about and be able to apply the principles and processes of health promotion and illness prevention relevant to the specialty.
- ***Scholar*** – To be involved in constant critical review of scientific principles and clinical precedent. To be knowledgeable to evaluate developments in research relevant to the specialty. To be able to undertake a research or evaluation study and critically appraise published research relevant to the specialty.
- ***Professional*** - *To* uphold the integrity of the medical profession and recognize the privileges accorded them. To be knowledgeable about the principles of medical ethics, the development of professional attitudes and mechanisms for the development and maintenance of clinical competence, acknowledging the need for professional and public accountability.

Applicants should also be aware of specific college criteria that are taken into account during the specialist assessment process. Information relating to college specific criteria is available at the website of the relevant specialist college as follows:

Australasian College for Emergency Medicine (ACEM) - http://www.acem.org.au

Australian and New Zealand College of Anaesthetists (ANZCA) - http://www.anzca.edu.au

Australasian College of Dermatologists (ACD) - http://www.dermcoll.asn.au

College of Intensive Care Medicine of Australia and New Zealand (CICM) - http://www.cicm.org.au

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) - http://www.ranzcp.org

The Royal Australian and New Zealand College of General Practitioners (RACGP) - http://www.racgp.org.au

The Royal Australasian College of Medical Administrators (RACMA) - http://www.racma.edu.au

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) - http://www.ranzcog.edu.au

The Royal College of Pathologists of Australasia (RCPA) - http://www.rcpa.edu.au

The Royal Australasian College of Surgeons (RACS) - http://www.surgeons.org

The Royal Australasian College of Physicians (RACP) - http://www.racp.edu.au

The Royal Australian and New Zealand College of Radiologists (RANZCR) - http://www.ranzcr.edu.au

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) - http://www.ranzco.edu

Australasian College of Sports Physicians (ACSP) – http://www.acsp.org.au

Australian College of Rural and Remote Medicine (ACRRM) – http://www.acrrm.org.au

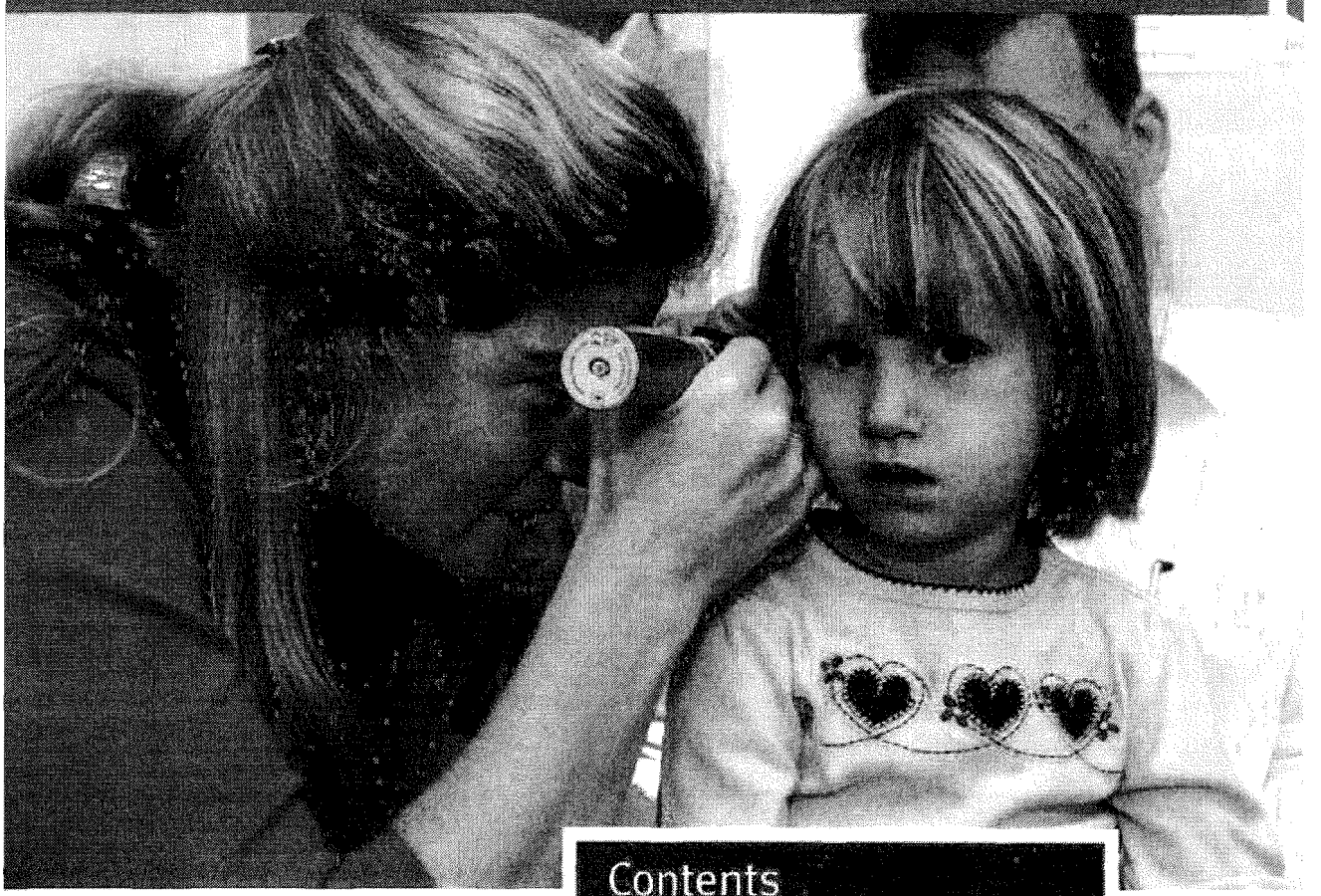
Royal Australasian College of Dental Surgeons (RACDS) – http://www.racds.org

Appendix L

Orientation Program for International Medical Graduates

Transition to clinical practice in Queensland Health: orientation program for international medical graduates

Orientation manual



Contents

Within this section you will find an Orientation Manual titled: "Transition to clinical practice in Queensland Health: Orientation manual for international medical graduates"

This manual contains information which will assist you to commence work in Queensland Health. Topics range from information about the health system in Australia, working in Queensland Health, legislation and professional practice issues, rural and remote services, communication and cultural safety, and living in Queensland.

You will also find a copy of the DVD presentation that you have seen in your two day orientation program and a multimedia information CD with additional information and resources for your reference attached to the folder.

Contents

How to use this Orientation Program

Welcome to *Transition to Clinical Practice in Queensland Health: Orientation Program for International Medical Graduates.*

Within this welcome package you will find:

- a Self Assessment form to help you identify which topics in the orientation package are most relevant to you and which sections of the resources have this information.
- a DVD of presentations containing important information regarding working as a doctor in Queensland (Note: if you do not have access to a DVD player, a Video Tape copy of the presentations can be requested from RAPTS@health.qld.gov.au)
- a CD of information and learning resources to supplement the DVD and Orientation Manual
- the Orientation Manual covering a broad range of information to assist you to begin medical practice in Queensland
- a section for you to place your Individual Learning plan
- an outline of mandatory and recommended topics covered in orientation and induction programs available through Health Service Districts (HSD). Specific District information can also be added to this section.

This orientation package is designed to cover the key areas which will help you to understand working in the public health system of Queensland. It is intended that you will have the opportunity to attend a facilitated orientation program using a combination of the above materials and local District information and staff. If you are not able to attend a facilitated program, the enclosed resources should provide you with an introduction to the standard practices, services available and overview of working and living in Queensland.

To maximise your learning experience we suggest that you use the resources in the following order:

- complete the Self-Assessment to identify your learning needs and to direct you to the most relevant sections of the package
- view the DVD presentations on key medical practice information. This may be viewed at your own pace and select one presentation at a time
- work through the orientation manual and refer to the Information CD for additional resources
- view the District Information provided in the Information CD and the orientation program folder. Your District should also be able to provide you with further information about your hospital and community
- insert a copy of your Individual Learning Plan when developed.

Orientation cd for International Medical Graduates

Summary Contents