

My Background

I am an NZ graduate medical practitioner who has been practicing in northern Australia NT and Queensland, mostly in remote and very remote areas, for more than 35 years. During this time I have worked in circumstances where the medical workforce was very understaffed, with many vacant and apparently unfillable positions. More recently numbers have increased ie less positions unfilled but the large increase in medical practitioners has been the arrival of International medical Graduates, most of whom are on Limited Registration –Area of Need. Many poorly prepared for the practice in which they find themselves. Often the patient population does not speak English as a first language, a population with very high complex chronic disease prevalence and frequent extremely acute medical emergency presentations. I have examined the AHPRA paper and wish only to comment on the English language skills registration standard. My perspective is Fairness to the practitioners who will practice in these difficult to staff areas with high needs for effective medical inputs.

My Assumptions

The English skills standards have been developed as a proxy for communication skills to support safe practice (the public safety imperative). The majority of international medical applicants have passed AMC Part 1 a clinical medicine written exam. The language used in the questions and required for answers is English. Within 5 years the applicants are required to study and pass an oral medical clinical exam, AMC part 2 and/or pass a specialist Australian Vocational assessment in English having studied advanced clinical medicine in English. Most of the specialist colleges also require extensive periods of supervised clinical practice in Australia (conducted in English) too. The English skills standard for registration is therefore also presumably testing to ensure that the limited registrants can work and study and succeed in studying and practicing to pass the required assessments within the required time. No credit is given for demonstration of the ability to study and pass the assessments as far as English skills are concerned.

Questions for consideration

1. My observation is that the registration standard is not a good proxy for communication to support safe practice. Many who pass the test have many other impediments to safe communication. In addition I have also worked with and supervised IMGs who have not passed the registration standard, but who are very effective and safe communicators. Hence my view that the proxy has problems. I feel it is entirely unfair that no credit is given for supervisor assessment of practice competence or communication skill, nor for demonstrated capacity to study successfully and to pass assessments in English. Currently the National Medical is liberalising the standards for demonstrated clinical knowledge and skill at the same time as operating a rigid English skills registration standard ie 'Australia prefers skilled English speaking doctors more than clinically competent doctors??'

2. No comment except to point out that over emphasis on English skills does not do anything for communication success with patients who are not English first language speakers.
3. No comment
4. I think that this is an area where some flexibility could be safely introduced. Some further assessment by clinical assessors in clinical practice could be allowed. I am thinking of assessments in live clinical practice situations. My college (ACRRM) requires assessment of communication adequacy of all trainees and prospective Fellows. The assessment matrix (part of their AMC accredited MiniCEX assessment) seems one practical way of doing this and producing a defensible assessment result.
5. Again there seems to be an opportunity to introduce some small flexibility here. The OET advice that their assessment would still be valid seems worth adopting. If nothing else such introduction would demonstrate a willingness to be flexible where possible. Encouraging research that might address some of the assessed shortcomings might also be helpful.
6. No comment.
7. No comment
8. My opinion is if the current status of the standards remains where English skills competence testing is more rigid and important than clinical knowledge and skills standards then the standards will eventually fall into disrepute.
9. The decision to require a common English skills registration standard to be the same for so many National Registration Boards may be adding unhelpful rigidity and an inability to reform. Unless change is possible this will be a limit to the development of evidence in an important area noted to be lacking evidence. However My submission would be that the earliest introduction of as much flexibility as possible will be the only reform that could meet my quest for a fairer system. This is based on the obvious large increase in Australian medical graduates already reducing the opportunities for the IMG medical practitioners that are contributing to the workforce now in established difficult areas of need.

Thank you for the opportunity to comment.

Dr Max Chalmers MB ChB MHP DRANZCOG FACRRM