From: Dr [redacted]
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To: Standard Consultation
Subject: Public consultation: review of criminal history registration standard and English language skills registration standard. Background

Date: 22/12/2013

Public consultation: review of criminal history registration standard and English language skills registration standard.

Background

I am a Bangladeshi medical graduate and general practitioner, had worked in NT for more than three years and 4 months in rural remote areas and area of need. I worked as a General Practitioner in Iran for more than 9 years. During my migration in NZ I studied Diploma in O&G and at the same time I passed my AMC part I component and English skilled Registration standard. After a successful passing of IMGPAC (International Medical Graduate Pre Assessment Clinical Interview) I had started my job as a General Practitioner in Northern Territory. However, within two and half years I passed my Australian Medical Council Clinical Component i.e. Part 2 and asked for general registration. By this time I have completed more than 2 years of General practice experience with a remarkable three of my Board appointed clinical supervisors report, declared as 'my experience as an advanced Medical practitioner'. When I asked for General Registration one of assistant Registration officer of the then Northern Territory medical Board replied that as **per telephonic conversation**(the non-medical assistant register) wrote that my communication was not satisfactory and imposed me to pass English skill test again. After several appeal to the NT medical Board by my clinical supervisors and myself the Board **stopped** my registration when I had completed my more than 3 years of general practice experience in Australia and **completed my AMC Clinical Certificate**. That decision was not based on any incident or patient complaint arising from my practice as a registered medical practitioner under supervision more than three years. In fact my practice supervisors reported regularly that my communication with patients was safe and over that time, with supervision and guidance, was showing a clearly improving trend. I never received any complain from any patients nor from any other departments. In the area of need, 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. Moreover, I appeared 2 times in [redacted] Fellowship written component but my attempts were unsuccessful due to stress and ongoing fear of losing registration. **In the AHPRA web site the English Standard for IMG'**s:3) a) '**has actively maintained employment as a registered health practitioner using English as the primary language of practice in a country where English is the native or first language';**

In my case this rule was not been followed by the NT Medical Board. I wrote too much about my own personal matter, but I think I don't have any other choice.

My Assumptions

As I am an international medical graduate 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. As I am a medical practitioner I do firmly believe that clinical knowledge is more important than the English standard. To explain that most of the English spoken countries the students have capacity to pass the English skill test but majority of them do not have the capacity to be a Doctor or could not be eligible to enter into the medical science. In my observation 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, in my view that the proxy for communication has some problems. I feel it is entirely unfair that no credit is given for supervisor assessment of practice competence or communication skill, or 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 [redacted] 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. . In cooperation with the AMC and AHPRA, The Competent Authority Pathway: The statement: **The evaluation for the AMC Clinical examination evaluation: The AMC Clinical Examination also assesses the candidate capacity to communicate with patients, their families and other health workers.**

The examinations are designed as a comprehensive test of medical knowledge, clinical competency and performance. Both are multidisciplinary and integrated.

The range of topics is based on the curricula of Australian medical schools, with an emphasis on conditions that are common in the Australian community. The AMC's Board of Examiners ensures that the format and content of the examinations are consistent with undergraduate medical courses and the standard of examinations in Australian medical schools. Members of the Board have broad expertise over the full range of disciplines covered in AMC and medical school examinations.

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. **Multiple sitting in OET Examination is also worthy**. Overview : Summery of the issue
dated 25/10/2013 'This is because linguistic research has shown that a range of affective and physical factors can influence candidate performance on the test day, OET considers that in these circumstances a single sub-test re-sit is justifiable'. We can also follow the English standard of countries like **USA or Canada**, **the leading contributor countries of medical science and medical technology**. 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. **According to the AHPRA web page of 3. The Board reserves the right at any time to revoke an exemption and/or require an applicant to undertake a specified English language test. In my opinion the Board should not be allowed to use so much power against a medical practitioner. When a Medical Practitioner is on the workforce and the whole family is dependent on practitioner's income.** My opinion is if the current status of the standards remains where English skills competence testing is more rigid and important that

clinical knowledge and skills standards then the standards will eventually fall into disrepute.

9. In my opinion, the decision to necessitate a common English skills registration standard to be the same for so many National Registration Boards may be adding unhelpful inflexibility 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.
My submission would be that the **earliest** introduction of **as much flexibility as possible** will be the only reform that could meet my expedition for a fairer scheme. This is created on the apparent 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**.

Thanks for the opportunity to provide a suggestion.