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Ageing

WellingtonNewZealand

Workshop on

Education and Training for Permanent Resident Overseas Trained Doctors

**Intercontinental Hotel
6 – 8 August 2003**

REPORT

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WORKSHOP ON EDUCATION AND TRAINING for PERMANENTLY RESIDENT OVERSEAS TRAINED DOCTORS

**Conducted
by the**

**Confederation of Postgraduate Medical
Education Councils**

Wellington
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The Confederation of Postgraduate Medical Education Councils

CPMEC is constituted by the following bodies:

Medical Council of New Zealand
Postgraduate Medical Council of Victoria
Postgraduate Medical Institute of Tasmania
Northern Territory Postgraduate Medical Council
Postgraduate Medical Council of New South Wales
Council for Early Postgraduate Education in South Australia
Postgraduate Medical Education Foundation of Queensland
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- The Medical Protection Society of New Zealand

Acknowledgements

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Disclaimer

The views and recommendations expressed and listed in this report do not necessarily represent the views of all those attending, but can be taken to represent the majority view.

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Glossary of Terms

ACCC	Australian Competition and Consumer Commission
AMGANZ	Association for International Medical Graduates in Australia and New Zealand
AMA	Australian Medical Association
AMC	Australian Medical Council
AON	Area of Need in this case an area, outside of hospitals of declared doctor shortage.
ASCMO	Australian Society of Career Medical Officers
BOTPLS	Bridging for Overseas Trained Professionals Loan Scheme
CPMEC	Confederation of Postgraduate Medical Education Councils
GP	General Practitioner
IELTS	International English Language Testing System
IMG	International Medical Graduate (synonymous with OTD)
JMO	Junior Medical Officer
MCATS	Multidisciplinary Clinical Assessment Task Scenarios
MCQ	Multiple Choice Question Assessment – Part I of the AMC assessment/examination process
MTRP	Medical Training Review Panel
NZMC	New Zealand Medical Council
NZREX	New Zealand Registration Examination
OTD	Overseas Trained Doctor. In this case specifically a Permanently Resident Overseas Trained Doctor who is required to pass the AMC examinations. (Synonymous with IMG.)
PMC	Postgraduate Medical Council
PGY1, 2, 3	Postgraduate Year 1 – synonymous with intern year Postgraduate Year 2, 3 – the second and third postgraduate years.
“Ready for Work” Programs	Programs designed to give OTDs an awareness of health issues in Australia and New Zealand, and including appropriate skilling in clinical procedural and professional skills.
SAPMEA	South Australian Postgraduate Medical Education Association
TOEFL	Test of English as a Foreign Language
USMLE	United States Medical Licensing Examination

Introduction and overview

The education and training needs of permanent resident overseas trained doctors in Australia and New Zealand were considered during a two-day workshop in Wellington on 7 and 8 August 2003.

Participants included overseas trained doctors, and representatives of educational, professional and regulatory bodies, and health services. More than 90 people attended the workshop, which was facilitated by Dr Norman Swan, Health Writer and Broadcaster.

Workshop participants identified gaps in the education and training of overseas trained doctors, and developed strategies to overcome these.

The workshop was very successful in providing a forum for the sharing of information and ideas, and for promoting networks, at an individual and organisational level.

The terms overseas trained doctors (OTDs) and international medical graduates (IMGs) were used interchangeably during the workshop and this has been reflected throughout this report.

It is anticipated that the recommendations from the workshop will form the background for the complete review of OTD education and training currently being undertaken by Subcommittee of the Medical Training Review Panel.

Professor Geoffrey Dahlenburg
Chairman
Organising Committee

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Edited by Professor Barry McGrath, Dr Anne Kanaris, Ms Carol Jordon, Postgraduate Medical Council of Victoria; Professor Geoffrey Dahlenburg, Council for Early Postgraduate Training in South Australia.

Executive Summary and Recommendations

Overseas trained doctors (OTDs) form an important and valued part of the medical workforce in Australia and New Zealand and make an important contribution by adding to the cultural diversity of the medical workforce.

It is likely that both countries will continue to rely on OTDs for the foreseeable future. Given changes in medical workforce patterns and demographics, medical workforce shortages are likely to remain an issue for some time.

The challenge for policy makers, health services, health professionals and organisations, and the broader community more generally is how best to utilise the skills of OTDs. There is also a need to acknowledge the impact that overseas trained doctors have on the existing medical workforce, through the demand for training and supervision.

There is also the broader issue of equity to consider, given that many OTDs come from countries with health needs greater than those of Australia and New Zealand. Australia and New Zealand should consider their role in training the health workforces of these countries.

There are widespread concerns about the education and training opportunities for OTDs in Australia and New Zealand. Overseas trained doctors are a diverse group, with varying skills and needs. Current processes and systems often fail to utilise their skills and meet their needs. This has implications for patient care, as well as raising issues of equity and fairness for OTDs themselves.

While there is some variation between Australia and New Zealand, the following issues were highlighted as key concerns:

- The lack of internationally agreed examination standards;
- The complexity of current assessment and registration processes;
- The lack of transparency in these processes;
- Inconsistencies between state processes in Australia;
- Insufficient support for OTDs, during assessment and registration and after they enter the work force;
- Lack of access to information for OTDs, especially at the start of the process;
- Deficiencies in communication and language skills;
- Current processes failure to recognise the diversity of OTDs' needs;
- Insufficient preparation of OTDs for entering the workplace and orientation to the local health system and society;
- Inadequacy of supervision, especially in 'Areas of Need' positions; and
- Need to assess safety and competency to practice.

It was noted, however, that many of the problems facing OTDs - such as inadequacy of supervision and support - are also issues for local graduates. Wherever possible,

initiatives to aid overseas trained doctors should be integrated into the broader system to support all doctors.

It was also noted that the issues around specialist registration and specialist pathways warrant greater consideration than could be offered by this workshop. It was suggested that a similar forum be organised, involving wide representation of the specialist colleges and other relevant bodies.

Key recommendations from the workshop

1. Greater priority to strategic medical workforce planning. The health sector must engage other sectors, notably immigration and education, in this work. The hospital workforce should be considered as a particular issue.
2. Improved access to “upfront” information and assessment of medical and language skills of OTDs - ideally, while still in their country of origin. This could include on-line examinations.
3. Pathways should be more flexible, and tailored to OTDs’ skills and needs. There needs to be uniformity in Australia, firstly regarding the AMC examination status of OTDs in relation to their employment as JMOs in hospitals, and secondly uniformity in recognition of prior clinical work in relation to internship requirements following successful completion of the AMC clinical examination.
4. Strategies to improve English and communication skills. The minimum standards of English language assessment should be uniform. Language and communication skills should be integrated into assessment, training and education processes.
5. Flexible, customised training and education opportunities are needed, including pre-employment or orientation programs. OTDs should have access to training and upskilling programs before and after reaching the workplace.
6. Greater support for OTDs, including case management, and mentoring.
7. Supervision of all PGY1s and 2s should be improved, although it is recognised that OTDs may have special needs. There is a need for performance measurement of supervisors, and improved funding, support and recognition for supervision. Inadequacy of supervision is a particular issue for area of need positions.
8. Monitoring and accreditation of orientation programs, education and training, supervision, and assessment. The goals are generic standards through education, employment and training; national verification standards (clinical guidelines for performance); and national guidelines for minimum clinical requirements prior to employment. The Australian Medical Council (AMC), postgraduate medical councils, medical boards and councils should be involved.

9. Seed funding to establish an Association for International Medical Graduates of Australia and New Zealand. Developing a cohesive, national voice for OTDs would help members, and would also help the policy making process by providing input and feedback.

While many reports over the past 20 years have identified concerns related to the education and training of overseas trained doctors there now appears to be a strengthening of the commitment of various stakeholders to action in addressing these concerns. In Australia, the Medical Training Review Panel's working party on OTDs offers a timely opportunity to effect change. As well, opportunities are likely to arise from the ACCC review of the Royal Australasian College of Surgeons, and the Australian Medical Council accreditation process for colleges. In New Zealand, opportunities are offered by the *Medical Practitioners Competence Assurance Act 2003* repealing the *Medical Practitioners Act 1995*.

Strategies for the future

Participants were asked to develop strategies addressing the following issues:

1. The big picture
2. The “front end” approach
3. Tailoring pathways
4. English and communication
5. Training and education
6. Supervision
7. Monitoring
8. National/trans-Tasman voice for OTDs

Each of these issues is discussed below.

1. The Big Picture

Medical workforce planning is dynamic and while participants proposed that there was no reliable data on OTD numbers in Australia or New Zealand it is clear that there are workforce shortages across a range of professions in both countries. Participants agreed that this was unlikely to change, despite increasing numbers of OTDs. This is largely because of changing workforce activities and hours worked (e.g. safe hours/safe practice review in Australia, lifestyle factors).

Recommendations

- The policy focus in Australia has been on maldistribution, but should also be on the micro environment.
- Australia needs to develop a national approach; New Zealand already has this.
- Given internationalisation and globalisation, there needs to be some policy focus on the international aspects of the market, including the role of Australia and New Zealand in training for the rest of the world.
- Inter-sectoral co-operation between health, education and immigration is needed.
- There needs to be greater focus on permanent resident OTDs. Recruitment of temporary resident OTDs seems to be increasing.

2. The Front End Approach

The adoption of the “front-end” model would enable OTDs to access comprehensive information via a website which gives access to a self-assessment and screening tool to test medical knowledge and English language, to determine their suitability to practice in Australia. If they appear suitable for practice, they would then access immigration requirements and then be linked to a site which explains the requirements for each state, GPs, medical boards, hospitals, specialist colleges (see Diagram 1).

Recommendations

- Better access to information is available to OTDs before they come to Australia/New Zealand.
- A representative in each state be identified to work together to establish a website and report back within three months.
- The Australian Medical Council allows the MCQ (multiple choice question) examination to be accessed on-line in OTDs' own country (after IELTS).
- That there be a mutually recognised international medical licensing exam.
- That postgraduate councils accept responsibility for information and direction of OTDs.
- A mentor register and networking/case management of OTDs be established.
- An OTD support group be formed, with office space and secretariat, to promote meetings for information and social events.
- The option of establishing a database with employment details be explored.

3. Tailoring Pathways

A crucial issue for OTDs is that the entry point for work in Australia varies from state to state, and that as such OTDs need easy access to comprehensive, consistent, accurate information, preferably via a website as described in the recommendations in Point 2 above.

Recommendations

- The crucial issue relating to the entry point for work in Australia, which varies from state to state, be recognised as critical in terms of equity and safety/competence, and as such, be addressed.
- That OTDs have access to an on-line screening process set to nationally consistent standards.
- That different pathways be developed which are based on whether the OTD is assessed as having equivalent or non-equivalent qualifications.

The proposed pathways are presented in Diagram 2.

4. English and Communication

As a priority, English language skills need to meet agreed minimum standards. In Australia three English tests, the International English Language Testing System (IELTS), Occupational English Test (OET) and Test of English as a Foreign Language (TOEFL) have all been used in the past, giving variable results. New Zealand is soon to implement a policy change allowing only IELTS with a 7.5 band plus a result of at least seven in each component.

Australia and New Zealand both allow exemption to the English testing depending on where people have worked or if English is their first language (see Diagram 3).

Recommendations

- A directory of relevant resources should be developed. Often an OTD is aware of their difficulties, but does not know where to go for help. Alternatively, OTDs should be able to access the English and Communication component of pre-employment courses.
- Communication skills training should be linked to cultural competency, which includes body language, colloquialisms as well as medical jargon, abbreviations, and acronyms. This training should be bidirectional.
- All doctors in Australia and New Zealand need to be culturally competent and to respect diversity. A cultural component could be part of continuing education and hospital in-service training for all doctors.

5. Training and Education

The following gaps were identified:

- Variable access to pre-employment or 'ready to work' programs for OTDs e.g. NSW, South Australia, and Queensland have programs, other states and New Zealand do not.
- No specific in-service training for OTDs once they are appointed to hospitals for their probationary year (year of "supervised practice"). Although many OTDs are likely to have clinical training and professional development needs that differ from locally trained graduates, this is not reflected in the current education and training offered in hospitals.
- No retraining programs for people with global gaps in their knowledge skill base. There are no tailored education and training programs for upskilling in specific clinical areas (as opposed to retraining across the board) and little recognition of prior learning of OTDs.

In proposing recommendations the following assumptions are made:

- That OTDs are heterogeneous with respect to their clinical skills, knowledge and familiarity with working in a highly developed western medical system.
- That OTDs will be screened either before they migrate or soon after they migrate to Australasia in order to determine gaps in clinical skills and knowledge.
- That the instrument used to screen OTDs is robust, sensitive and recognised internationally as valid and reliable for western medical systems.
- That language and communication skills testing are widely available.
- That English language proficiency especially in a clinical context has been assessed and the required level of competence has been attained by the OTDs.

Proposed Solutions

Solutions designed to address the identified gaps in education and training for OTDs are summarised in Diagram 4. The process requires that:

- **OTDs identified by front-end assessment as having a global deficit in their skills should be trained by staff in medical schools - they should be allowed to complete the second last or last year of a medical course. Places could be created if funding was made available, and greater use could be made of the private sector.**
- **OTDs identified by front end assessment as having specific gaps would be given flexible, tailored, modular training which met clearly defined standards. A range of education service providers might be interested in providing training; for example, consortia/private sector/bridging programs/universities and could get clinical access through community practice, skills laboratories, the private hospital sector (teaching hospitals are too busy). The private sector is keen to participate.**
- **Specialty colleges should be involved but could utilise existing material from other sources.**
- **A common curriculum for a “ready for workforce program” across Australia could be developed. A working group could be formed to develop a national curriculum.**

Appropriate levels of funding will be needed to expand the range of education service providers.

6. Supervision

The recommendations made regarding the structure of supervision apply not only to OTDs but to all PGY1s and PGY2s. It is the view of participants that all junior medical officers should be able to access a similar structure at any hospital where they work. Since there is a diversity of hospitals, the system needs to be flexible.

There was recognition that some overseas trained doctors go straight into a rural practice or community settings but the majority come into a hospital setting; the focus is on OTDs in the hospital setting.

The focus of the recommendations is on the supervisor. It was acknowledged that the buddy and mentor systems already in place in some hospitals can run in parallel or overlay the structure proposed. (see Diagram 5).

Participants distinguished between the roles of buddy, mentor and supervisor.

- A buddy is available for a short time (2 weeks). One type of buddy would introduce and help orient the IMG to the workplace. Another type of buddy would be an IMG providing peer support. This approach would be informal, and unresourced.
- A mentor spans the career, is external to work, and does not have to be a doctor. They are an advisor and advocate.

- A supervisor is generally appointed by the hospital, is for the medium term (one year) and can involve remediation.

Recommendations - What is needed?

- Teaching skills for supervisors
- Protected time for supervision
- Support for PGY supervisors (resources, Medical Education Officers/Units)
- The introduction of medical clinical educators
- Performance management of supervisors
- “Pressure” from “the top” to make the system work
- A sense of responsibility in our supervisors; supervisors are not equal to evaluators

Principles of supervision include: oversight, mentoring, encouragement and motivation; use of adult learning practices; availability and locality; and assessment. Supervision takes account of structure and seniority of supervisor/mentor. The Medical Council of New Zealand is reviewing guidelines for supervisors and a document will be available soon.

Supervision should be aimed at the application process, examinations, bridging courses – in other words, be equivalent to case management.

Recommendations

The following recommendations were identified for both overseas trained doctors and local graduates.

- Educators need to be available on the ward, akin to the nursing structure; to give one-on-one support; clinicians do not recognize this as their role.
- Medical clinical educators should teach techniques/or procedures, for example, a registrar in each hospital, should be designated.
- Senior Medical Officers should be trained to undertake supervision.
- Supervisors should be alongside to explain or assist when OTDs or other junior medical officers start their first position. There should be a designated person to ensure the hospital or general practice has necessary systems in place (recognising the difference between supervisor/buddy/mentor).
- Proper evaluation and reporting on the doctors’ performance during the term/run is required.
- A greater awareness that supervisors need to report accurately on the level of communication skills of OTDs; “ticking the box” is not an adequate response. Supervisors often have limited contact with probationary staff so need to seek feedback from other team members, such as nurses.
- Informal supports should be available and made known – for example, a person available for a chat/coffee (maybe someone part of an OTD network).
- Oversight to ensure evaluations are satisfactorily completed, sent to the appropriate bodies and that remediation occurs where necessary.

- Identification of people to help OTDs with decisions regarding what to do next in their medical career.

7. Monitoring

Participants identified a need to monitor and accredit orientation programs, education and training, supervision, and assessment (see Diagram 6).

Generic standards through education, employment and training; national verification standards (clinical guidelines for performance); national guidelines for minimum clinical requirements prior to employment (the CPMEC has recently reviewed accreditation and training guidelines for junior medical officers) should be the goal.

There is no real way of monitoring OTDs in 'area of need' (AoN) positions once they are recommended by Rural Workforce Agencies for employment and approved by the respective Medical Board. This is a particular issue for Queensland. The Postgraduate Medical Councils in association with the Medical Boards/Council should provide an assessment as to the appropriateness of OTDs to work in an 'area of need' position. Such assessment should consider English and communication levels and clinical and professional competence.

A full orientation to the health system, in Australia and New Zealand, as appropriate, is required.

Recommendations

- The minimum standard for entering practice should be the AMC clinical exam or its equivalent.
- There needs to be an external system of accreditation of doctors sent to 'area of need' positions by rural workforce agencies in each state.
- Postgraduate medical councils (as agents of medical boards) should have responsibility for accreditation and monitoring, including accrediting agencies such as the Rural Welfare Agencies, to ensure standards are met.

These measures are largely already in place and could be implemented by Confederation of Postgraduate Medical Education Councils (CPMEC) or postgraduate councils in each state by the end of 2004.

8. A National Trans-Tasman Voice for OTDs

The establishment of an organisation to be called AIMGANZ (Association for International Medical Graduates of Australia and New Zealand) was proposed. This organisation should be an independent, non-political organisation providing peer support and advocacy and linking IMGs across the Tasman. Observers (possibly non IMGs) could attend to provide extra advocacy but the Association would be independent and facilitate educational outcomes for sustainable employment of OTDs/IMGs.

A trans-Tasman meeting (video conference option, with multiple sites possible) with election for positions is proposed. Association members could vote to include students and those in a range of medical and non-medical disciplines. There would be local state-based structures which feed into national and international structures.

This Association should be represented on government bodies, such as Australian Health Ministers' Advisory Council (AHMAC), the Medical Training Review Panel (MTRP), and the Australian Health Workforce Advisory Committee (AHWAC). The New Zealand IMG body, Overseas Doctors Association (ODA), already does some advocacy and has some Medical Council input.

The agenda for this new association could include:

1. Membership
2. State reports
3. Exam feedback
4. Training options
5. Peer support

Impediments to progress the development of such an Association include IMGs reluctance to be involved because of fears of career/personal attack, and limitations due to the target group being disempowered/disenfranchised. It is therefore important that the group be seen to be non-political/bureaucratic and non-threatening.

Seeding money will be needed to enable formation and meetings of the association. It is envisaged that once established, the members would fund the organisation with scope for sponsorship by other groups.

Recommendations

- Volunteers organise the formation of an Australian group and links with New Zealand (to start immediately)
- A national website should be set up (by volunteers and completed by end August 2003) which should include membership form, email group and contacts for IMG mentors; It could link from the AMA/AMC/ASCMO/PMCs/CPMEC websites.
- Establish administrative arrangements - banking/ABN/registration as a non profit organisation (complete by designated time)
- Establish an email database (on a state by state basis). This is an ongoing process but should make substantial progress by end of October.
- Identify resources and senior IMGs. This is an ongoing process but should make substantial progress by end of October.
- Publicise agenda for national meeting and ask for further items and executive nominations. On going agenda determined by the meeting.
- Identify sponsors for national secretary plus national inaugural videoconference. Meeting in early December.
- Appoint a National paid secretary; responsible for ongoing agenda set by executive with consultation.

Diagrams and Flow Charts

Diagram 1: The Front End Approach

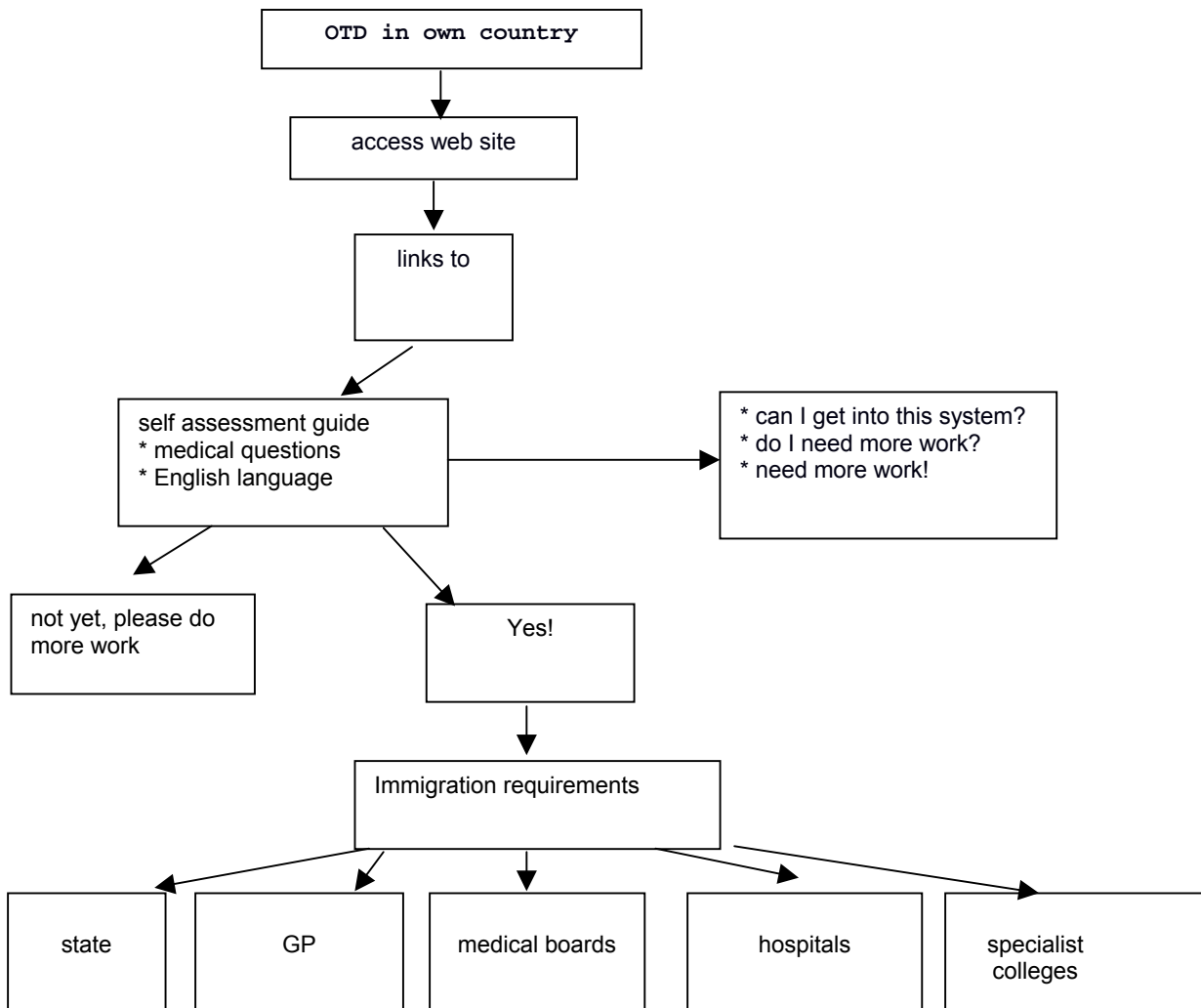


Diagram 2: Tailoring Pathways

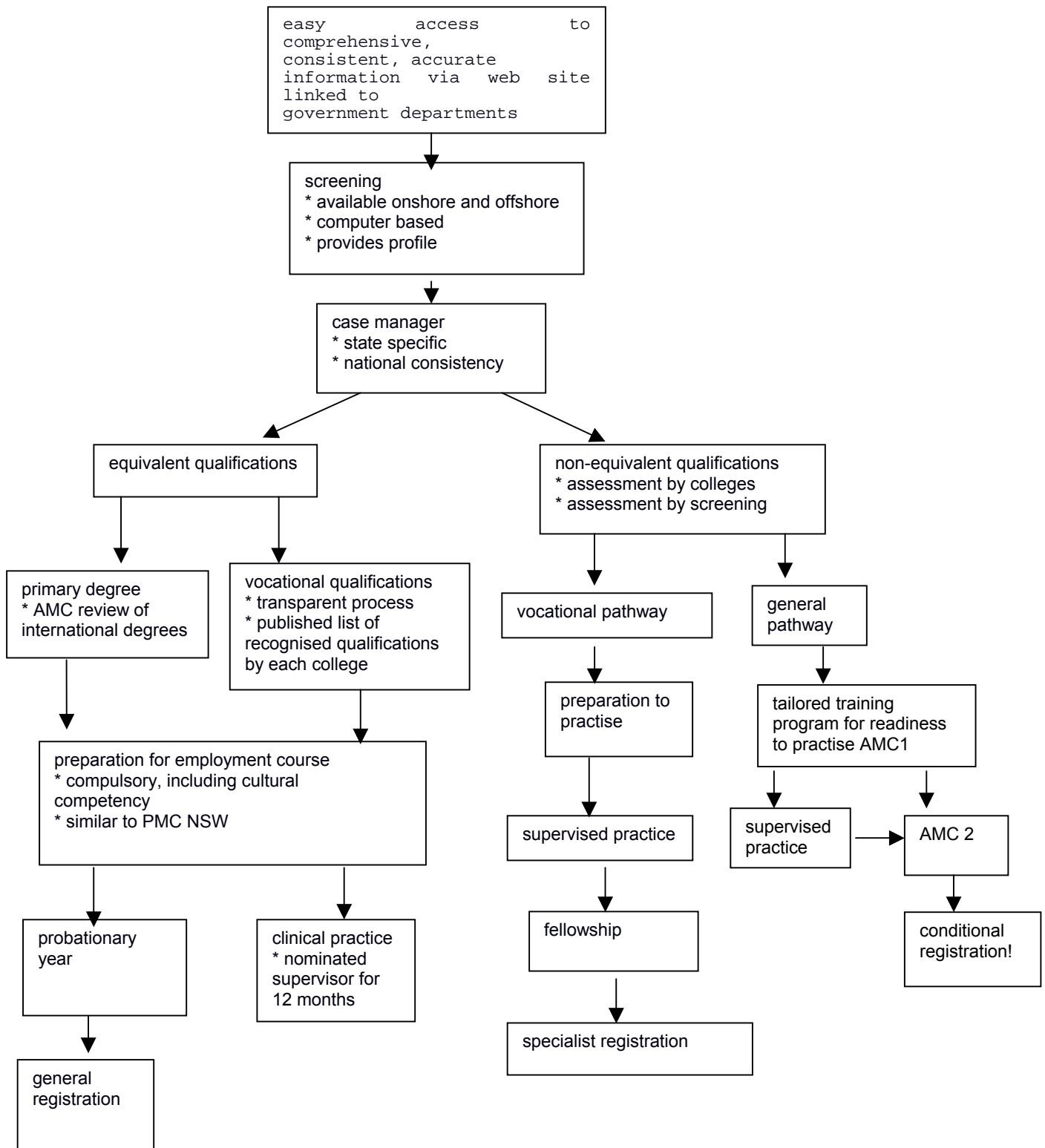


Diagram 3: English and Communication

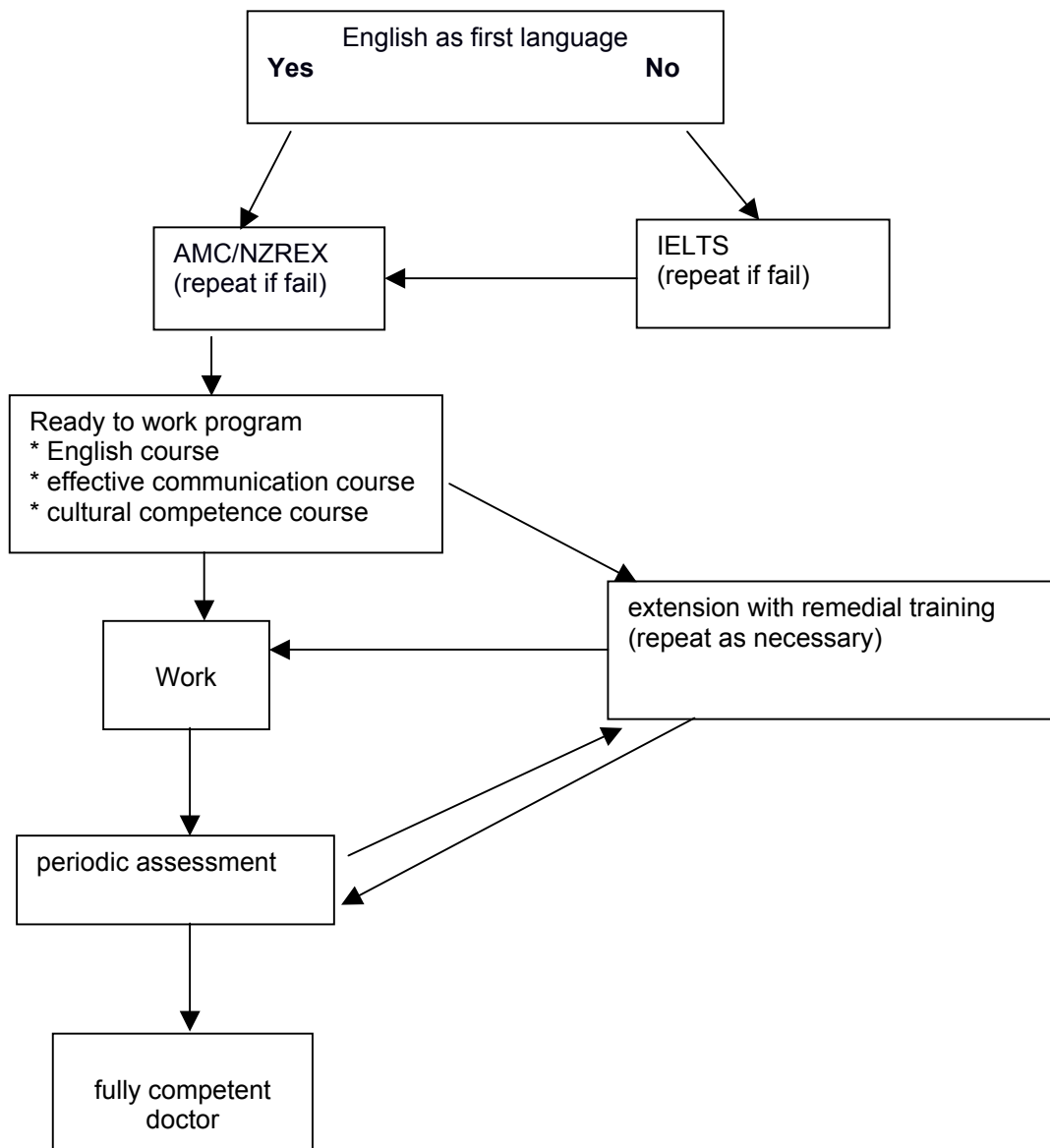


Diagram 4 – Education and Training Strategies

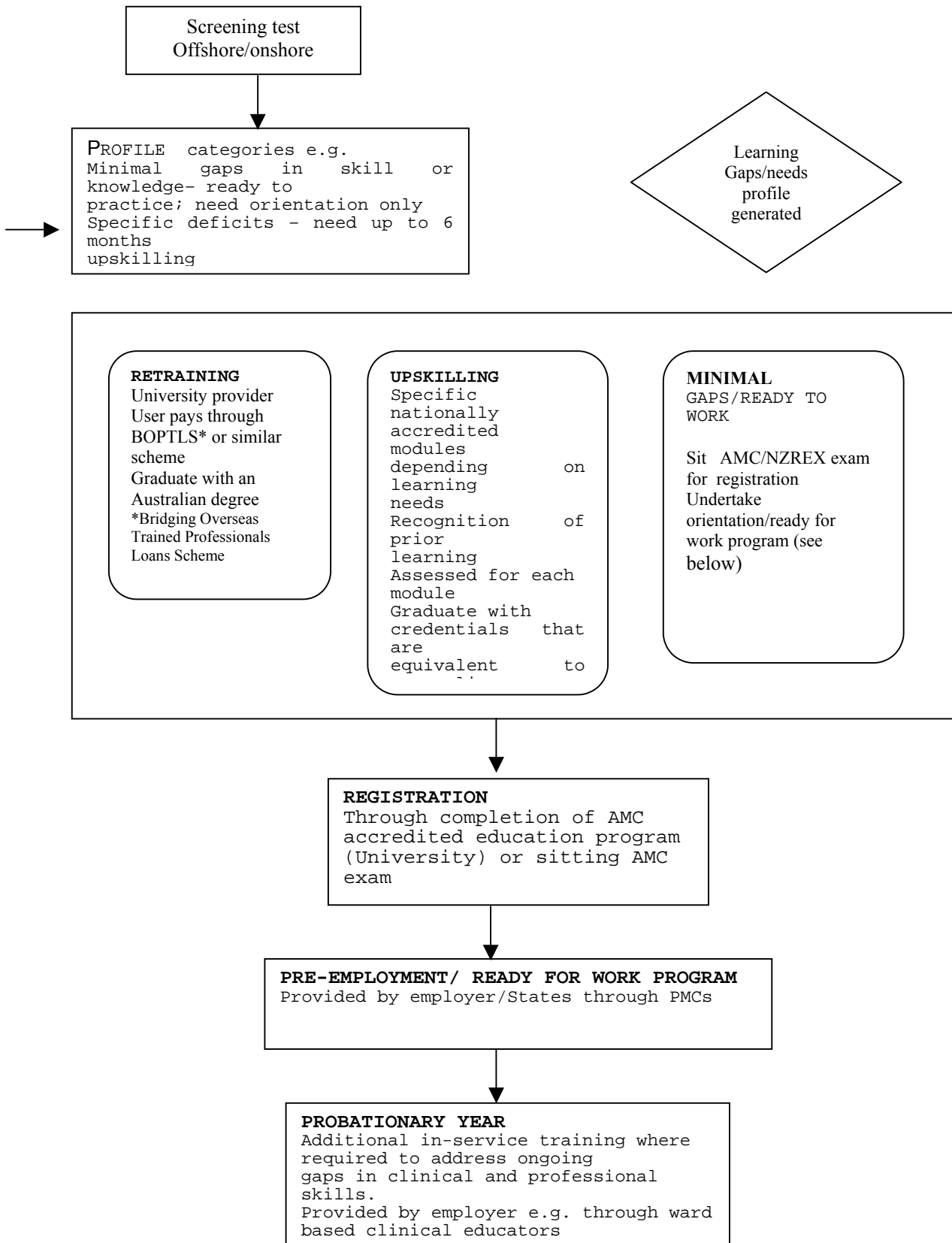


Diagram 5: Supervision

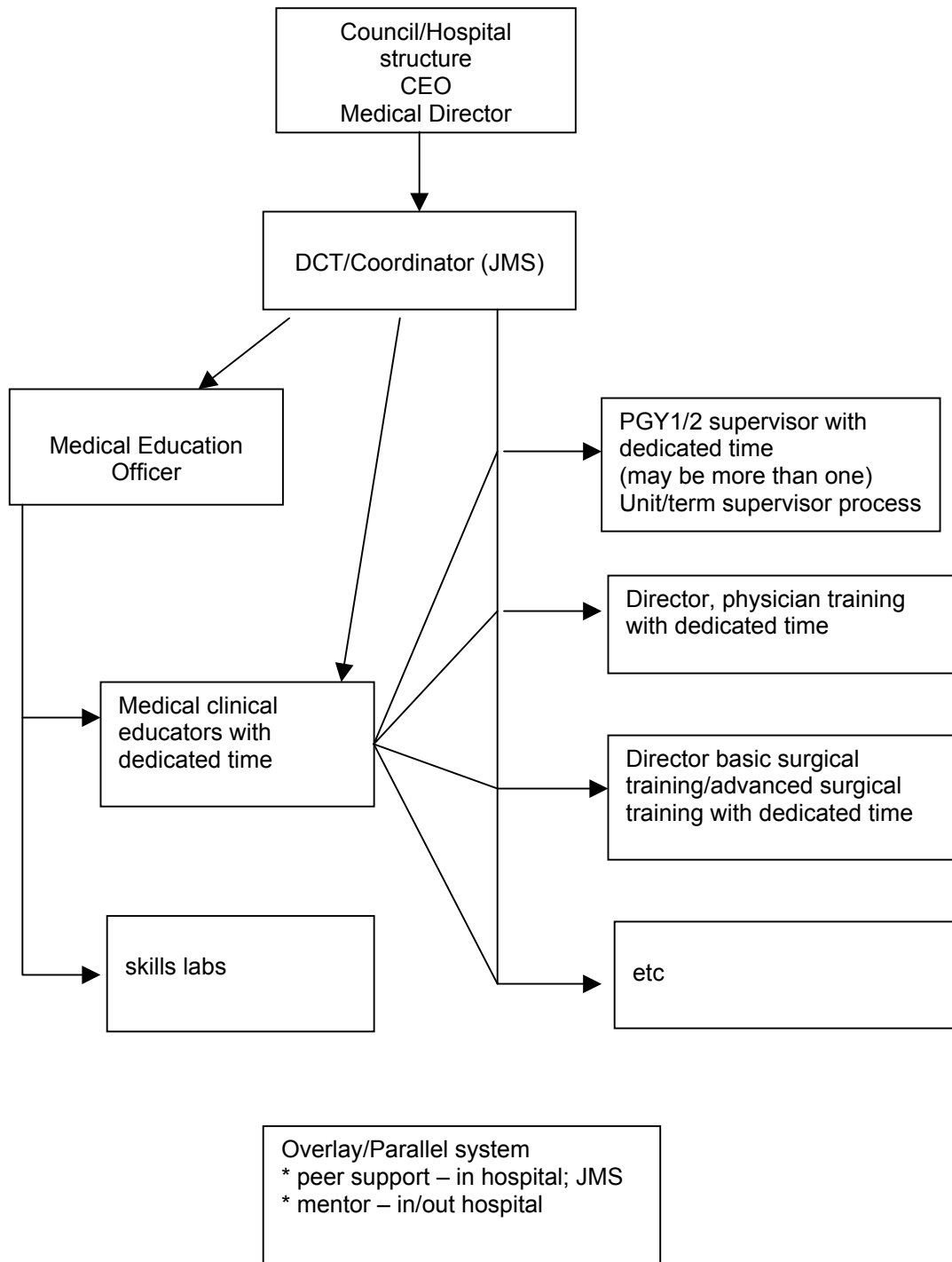
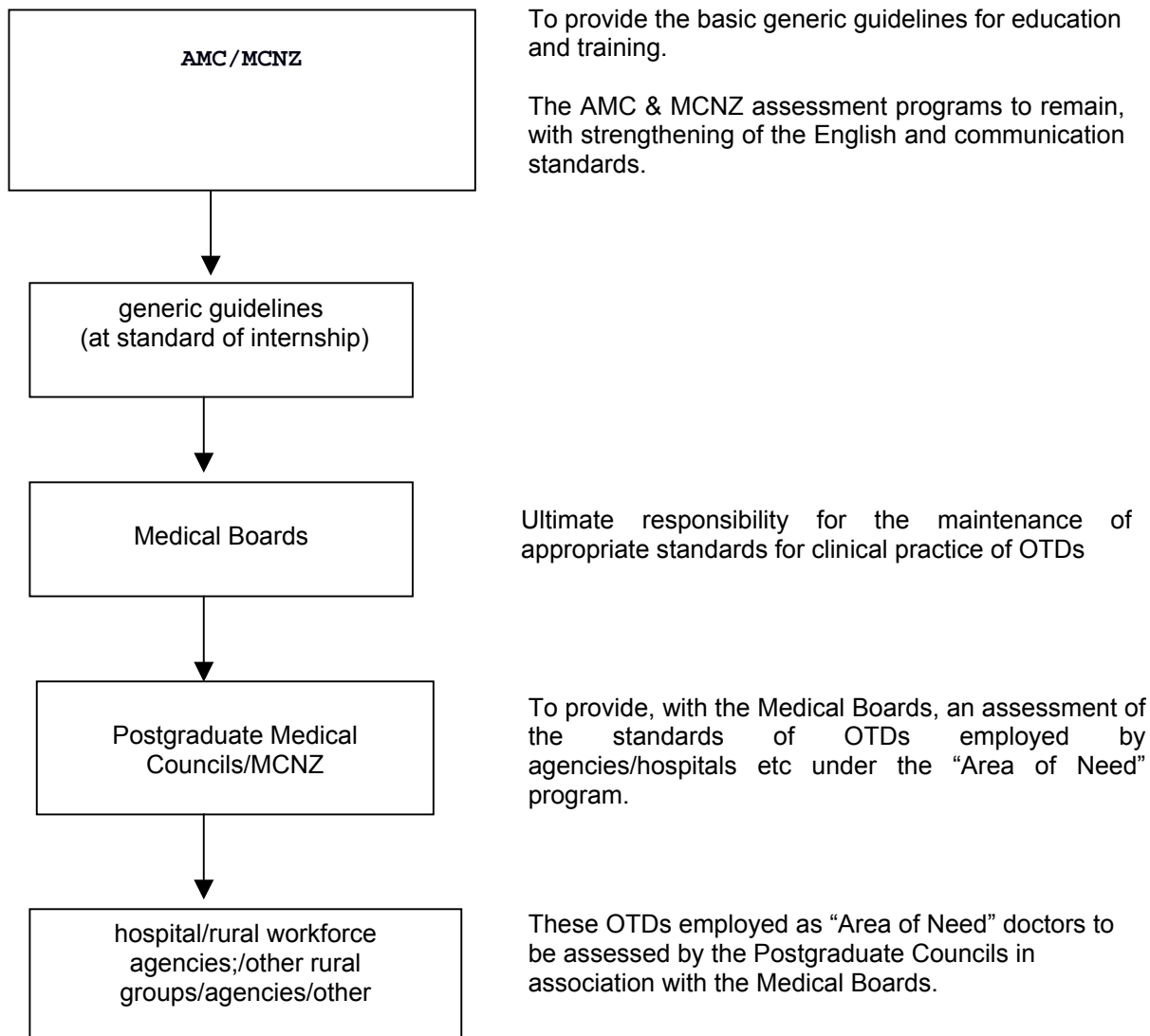


Diagram 6: Monitoring



Appendices

From the Inside Looking Out

Mr Greg Jemsek Co-coordinator of Medical Education and Training,
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IMGs (International Medical Graduates) are viewed as an enigma, a burden and even sometimes as saviors of the health system in Australasia. All of these perceptions have some truth. But in the main, IMGs are an accidental nucleus of a major change happening in the health system generally. Their presence points us to broader issues, including the most important one all of us in this industry face: “What will health care look like in the future?”

This larger question leads us to the smaller but quite significant ones I wish to focus on with you today. Questions that face rural communities, hospitals, medical training institutions, and IMGs themselves. These questions are:

“What implications does the mobility of the medical workforce have on not just the countries taking doctors in, but the countries being left?”

“How can we confidently assess overseas trained doctors without damaging the recruitment efforts of the healthcare agencies desperate for their services?”

“How can the educational institutions already here – the universities and the colleges – serve the needs of IMGs and hence those of the community?”

“Is the overseas trained doctor an untapped resource that can enrich the Australian, Aotearoa health system rather than simply plug a workplace shortage?”

I wish we had time to look into all of these questions in depth at this gathering. But doing so would, perhaps, do none of them the justice they deserve. The issues raised by each question will not be going away anytime soon, and so my hope in raising them is to at least trigger some initial reflection on those issues, and to provide the broadest possible perspective from which we can then focus our energies on more immediate concerns.

Before leaving them altogether, however, I’d like to remind you of a tool I have found useful in considering these and other matters in my role as medical educator at Goulburn Valley Health in Victoria. That tool is no doubt familiar to most of you, but a reminder of its’ usefulness can direct our inquiry.

I’m referring to systems theory, the capacity to stretch back a bit from the nitty gritty of difficult problems into a perspective that reminds us of forces that might be affecting our issues of concern. I’d like to review with you four principles of systems theory, taken from several sources but two in particular I’d like to acknowledge: Peter Senge and Margaret Wheatley. I refer any of you interested in more depth on how systems operate to any of the writings by these two systems theorists.

The first principle I think is important to consider when examining the issues IMGs face and we face with them is this: *A systems approach focuses on dynamic complexity – that is processes and relationships - rather than detail complexity.* Dynamic complexity is much more elusive to gain traction on than detail complexity for the simple reason that time works against us, as does the ethos of productivity and constant improvement. We think if we take a step back, we will lose traction in the problems we are attempting to solve. In fact, the opposite is true -if you focus too much on the details, you usually end up neglecting the processes and relationships that need to be addressed, and end up putting in place “solutions” that invariably create more problems.

That, in essence, is the second principle I’d like to mention: *All actions taken in a system are both cause and effect, and the effect is usually delayed.* For example, in the early 1990s, the Commonwealth took action to reduce medical supply, which had a delayed effect of generating a shortage of doctors in rural areas. What looked in the short term to be a cost-saving measure, in the long term has cost far more in both economic and human terms. Stepping back from the detail, surveying the whole field of medicine, getting advice from all the parties affected, would have, in my opinion, been a wiser course to take. The actions we take always have an effect down the track and that effect is largely unpredictable; that is why “going slow to go fast” is a helpful strategy when taking on such a large predicament. Solutions to such large-scale problems will be largely unknown and require a creative, consultative process.

The next principle is equally important: *Systems in transition reorganize around an identity, a sense of meaning.* What is the purpose of the current health care system? Is it to make as many people well in the population as possible? Is it to offer a higher standard of care to those with private insurance? Is it to encourage doctors to practice in the city rather than the country? Is it to inform the community of steps they can take to prevent many of the illnesses they currently face?

Most people assume the first – making as many people as well as possible – and indeed, the invention of the Medicare system reflects that sentiment. But many of the actions taken in recent times, including the sometimes desperate means of addressing workforce shortages in rural areas, indicate we have lost sight of this identity. Do we reclaim it in its’ old form, evolve it to something else, or declare another purpose? So far, we have just let the identity, and the vision, for health care in the 21st century simply drift. Is it any wonder that IMGs coming into the country are given such short shrift? That there is no thinking going on as yet to truly integrate this resource through mapping career pathways through the colleges for them, for instance? That much of what they are used for are jobs Australian trained doctors are moving away from for reasons ranging from social needs to insurance costs?

All of that can seem a bit overwhelming, which is why I want to introduce this last principle as a type of reassurance. The principle is this: “A ‘pretty good solution’ is sufficient for a system in transition.” Does this mean a lowering of standards? Not at all. To the contrary, it reflects the complexity of a systems problem, and the need for experimentation to find a solution. As doctors you know that, at best, only 50% of medicine is evidence based. New diseases, new manifestations of old diseases,

increased interaction between the many things that cause disease, mean the medical world is facing as much uncertainty as to what to do about ill health in as many areas as it ever has. This is not to diminish the advances that are being made, and the hope that is being generated, from medical research. It is merely to note that such research has to peddle furiously to keep pace with the directions health is going. This has always been the case, of course, which is why in the US - and perhaps here as well - some doctors freely lent their support in the 1950s to the cause of cigarette smoking as a means of relaxation and better health. We know that's preposterous today, just as we know that various technologies we have employed in the past have caused more harm than good.

But that is, nonetheless, consistent with the notion that complexity must be met with some degree of experimentation. How else will new solutions be found? And as it is with disease, so it is with determining how best to deal with the changing face of our medical workforce. What experiments must we try? In Perth, for example, a consortium of professionals brought together by PTAC recently decided on an experiment where IMGs out of work for some time would be considered in the same light as Australian trained doctors re-entering the workforce. What will come of this experiment? We don't know right now, but the thinking around the table that brought it to bear was in fact reflective, involved the opinions of many, and took an attitude of care and respect in its considerations. That increase though does not guarantee a successful outcome, and is no doubt a "pretty good solution" to the current situation of having many unemployed IMGs in WA attempting to get back to a medical career of some variety or another.

Against this backdrop we have the focal point of this conference, a question posed to all of us:

"If we are to increasingly rely on overseas trained doctors, how are we to educate and train them?"

With all due respect to the importance and centrality of this issue, and indeed my own interest in it, I suggest to you that *this is perhaps the wrong question*.

It is not wrong in and of itself, but only in the sense of what it potentially omits. I want to point out those risks, because if we acknowledge those risks of omission we can attend to them and use them to inform our conversations. Then the question rightfully gains the centrality it deserves, and focuses our efforts here today.

The first omission has to do with educational dogma. We have a tendency, when we get caught in the details instead of viewing the larger complexity, of looking for things through a purely problem-solving lens. The latest, greatest tool for this endeavor is educational technology. Learning objectives. Problem based learning. Feedback systems. All these methodologies are fine and indeed useful in their place. But if we embrace them ideologically, as be-alls and end-alls to our problems, we will be selling ourselves short. We'd be doing so for the simple reason that accountability and efficiency overlook the *art* of medicine, the immeasurable capacity good clinicians have to make judgments in the absence of definitive information, dealing with cases on their own merits, and perhaps never replicating exactly what is done again because of the

uniqueness of the case in front of them. We must avoid turning education into dogma, and put it into perspective.

The second omission concerns the human dimension of doctors we are bringing to the country from overseas. Not that this isn't a factor with Australian trained doctors as well; the rise of interest in topics such as "The Junior Doctor in Distress", addressing personal discontent and destructive behavior within the profession is testimony to that. But IMGs are more complicated still, because of the much larger degree of uncertainty and lack of knowledge we have about their background. What personal circumstances brought them here in the first place? How different was their training, and how different were the patients they saw? What will life be like for the families they are bringing with them? Any plans for education and training of IMGs must step back and put itself within the context of these and other questions, because then and only then will we have an inkling of why our strategies do or do not work. I'll speak more to this in a moment when I address the issue of culture a bit more closely.

The third and final omission concerns centrality vs. locality. What aspects of education and training need to be common? What should be specific to the area in which it occurs, both in terms of content and in terms of who delivers it? Uniformity has unquestionable benefits, but is, like educational fundamentalism, unable to deal with out-of-the-box situations unless it also incorporates the local situation. How do GPs in a rural area 200 Ks from the nearest hospital get trained relative to those practicing in central Sydney or Melbourne?

This brings us to three questions I hope will inform this conference throughout our deliberations. The first is probably beyond our brief, the question I opened this talk with: "What sort of doctors do we want in Australia/Aotearoa?" And yet while I begrudgingly accept that considering this more philosophical orientation in detail could take us away from the very pragmatic issues that brought us here, I invite us all to do this: Keep this question in your mind as you chart out your suggestions, and use it as a mirror in which those suggestions can be reflected. If you think IMGs need greater access to the college training programs already existing in Australia and Aotearoa, for instance, what would the implications be for the type of medicine we hope to bring forward in the future?

Culture

The second question is more accessible to the purpose of this conference, and one I particularly value because it reflects several of the "little experiments" I've just encouraged you to try in bumping the system a bit. That is the question of culture.

There's a tendency to think of culture in terms of geography: the culture of origin of a particular person. As important as that is, it overlooks a broader and, I think, more relevant view of culture. Let me use an example to illustrate. Recently, a colleague rang me and said: "We have an IMG who turns up late to shifts and is not really paying attention to the job. Do you know anything about this doctors' culture (he was Syrian) in terms of how we deal with this doctor? What should I do?" I was a bit taken aback by this question because its' assumption that the problem had to do with the doctor's culture of geographical origin. I asked my colleague a simple question: "Have you

asked the doctor why this is happening, have you talked to the doctor about what is going on?”

In other words, it is far too easy to neglect the *health care workplace culture*, the culture of the hospital. We take this for granted when we work in hospitals, but if you were to take the time to ask a patient who had never been in a hospital before, or hadn't been since their birth, if there was a definite 'culture' about the place, they would, I suspect, respond with a resounding yes. A culture very influenced by things such as technology, science, speed, medicines, death, suffering, to name just a few. This is, from my experience, the culture IMGs are most concerned with when they arrive, and one with which they have the most overlap with other health care professionals.

Central to this is a simple observation I hope all of you have made: When a person takes the risk of moving to a new country, uprooting their family, putting their most valued and enduring relationships under extraordinary stress, they are *very motivated* to succeed. *It's the place where they work they will most want to feel part of.*

So how can we cultivate a supportive work culture? How can the training and education we propose actually assist in making a person feel more a part of that culture rather than less?

These considerations bring to bear a point seldom considered in deliberations about IMGs but absolutely central to us being able to utilize this wonderful resource and hopefully solve some of our own problems in the process. That point is simple: cultural change has to be in both directions. Why is cultural training limited to IMGs? If an IMG one week into the job makes a bad decision about fluid balances for a child in emergency and is publicly chastised by his supervisor in front of other staff, who has the cultural problem? If a medical resource officer schedules an Islamic doctor to work on Ramadan or another significant religious holiday without finding out that this may be important to him or her, who has the cultural problem?

This is why we must consider this question: “What would have to happen to introduce cultural training inclusive of hospital administrative, medical and nursing staff as well as IMGs? What would such training look like?” It's a sad reflection of our incapacity to think of IMGs as part of the hospital culture that this question is so seldom raised.

The importance of being local

As a final point to consider to frame our discussions about IMGs, I'd like to bring up the importance of local interventions. I work day to day with IMGs in a 250 bed rural hospital. Nearly half of the doctors there are IMGs. Every year we have a formal sit down to go over the learning objectives and every week involves catching up on domestic/personal/financial issues. These conversations have had a remarkable commonality. A commonality that hearkens back to the importance of hospital culture, because it is that culture where the solution to many of the issues they face does, in my opinion, lie.

What IMGs say they want at work is....

1. Better *Supervision* from senior staff - to get constructive/negative/helpful feedback. It is not only a problem for IMGs. Australian graduates say the same thing.
2. Some form of *Mentoring*. Particularly in the first year of employment, the need is strong for oversight of their process on a very individual level from a trusted authority distinct from the ones who will determine their economic progress.
3. Greater *Networking* Opportunities. I suspect what's behind this request is a desire to be more incorporated into the local hospital culture. The meeting of and exchange with others in the profession.

One of the best things that has happened in our local hospital is we have made an extended effort to help IMGs meet GPs in the community. Many of them find the notion of the GP as gatekeeper a bit of an anathema, but having actually come face to face with them now, that concern is receding. This same principle applies to situations within the hospital, where IMGs need support in attending and participating in integrative events such as Grand Rounds and Audit Meetings. All of this helps the adjustment and informs the training needed to be undertaken.

It also leads me to the final question I would invite you to consider: "What would need to happen to initiate and sustain the supervision, mentoring and networking approaches I'm suggesting? How can we take IMGs under our wings and help them to become proficient within the Australian system? How can local health providers contribute to this process?"

A final note on these suggestions. They are, quite obviously, labor intensive strategies. Ironical in light of the fact that bringing IMGs over to Aotearoa and Australia was meant to quickly and painlessly solve a workforce shortage without having to be labor intensive. But as always when detail complexity usurps dynamic complexity, this creates additional problems we all now face.

I hope these comments will assist all of us here today to view IMGs more honestly, as human beings with a contribution to make, as professionals ready to make the Australian and Aotearoa health systems better than they now are. If we address the issues systemically, with an attitude of care, consultation, and consideration, I've not doubt this will happen.

Comments on the Paper included the following:

Who benefits from the current system and what are the responsibilities of the system to IMGs?

Is it reasonable and/or fair for wealthy countries to rely on IMGs? In countries where IMGs are coming from, there is concern about active recruitment and poaching by wealthier countries.

Solving a shortage problem creates an increased need for training and supervision. This highlights a weakness in how resources are utilized and dispensed.

What are leverage points in the system as it is? Two critical ones are the direction and amount of *funding*; i.e. will the Commonwealth and the States support the education and careers of IMGs? Secondly, how can the as-yet-unheard *voices* of IMGs be galvanized to speak their concerns and contribute to the overall debate about where the Australian and New Zealand health system is headed?

“From the Inside Looking Out”

Greg Jemsek
Goulburn Valley Health
Shepparton Victoria

Slide 1

What implications does the mobility of the medical work force have on not just on the countries taking doctors in, but the countries being left?

How can we confidently assess overseas trained doctors without damaging the recruitment efforts of the healthcare agencies desperate for their services?

How can the educational institutions already here - the universities and the colleges - serve the needs of OTDs and hence those of the community?

Is the overseas trained doctor an untapped resource that can enrich the Australian, Aotearoa health system rather than simply plug a workplace shortage?

Slide 2

Systems Theory

- Systems thinking focuses on dynamic complexity(processes, relationships) rather than detail complexity.
- All actions taken in a system are both cause and effect, and the effect is usually delayed.
- Systems in transition reorganize around an identity, a sense of meaning.
- A “pretty good solution” is sufficient for a system in transition.

Slide 3

**“If we are to increasingly
rely on overseas trained
doctors, how are we to
educate and train them?”**

Wrong Question!

Slide 4

Question 1:

**“What sort of doctors do we
want in Australia/Aotearoa?
How do OTDs fit into that
picture?”**

Slide 5

The Importance of Culture

- In the Health Care Workplace
- In both Directions

Slide 6

Question 2:

“What would have to happen to introduce cultural training inclusive of hospital administrative, medical and nursing staff as well as IMGs? What would such training look like?”

Slide 7

The Importance of Being Local

- 1. Supervision**
- 2. Mentoring**
- 3. Networking**

Slide 8

Question 3

“What would need to happen to initiate and sustain the supervision and mentoring approaches I’m suggesting? How can local health providers increase IMG networking opportunity ?”

Slide 9

The Three Questions

1. “What sort of doctors do we want in Australia/Aotearoa? How do IMGs fit into that picture?”
2. “What would have to happen to introduce cultural training inclusive of hospital administrative, medical and nursing staff as well as IMGs? What would such training look like?”
3. What would need to happen to initiate and sustain the supervision and mentoring approaches I’m suggesting?
How can local health providers increase IMG networking opportunity?”

Slide 10

What goes in New Zealand?

Dr Deborah Read, public health physician and Deputy President and Chair, Education Committee, Medical Council of New Zealand

Overseas trained doctors (OTDs) are a significant part of the New Zealand medical workforce. In 1990, OTDs were 29% of the NZ medical workforce. In 2003, they are 40% of the medical workforce (n = 5270). Permanent resident doctors are 37% of the medical workforce (n = 4512).

OTDs account for more than 50% of doctors in 25 of 58 non-city areas. In contrast they are more than 50% of doctors in only 1 of 15 city areas.

OTDs come from 82 countries, predominantly England followed by South Africa.

OTDs by country of primary qualification

England	1219
South Africa	831
(Australia	382)
Scotland	366
India	353
Sri Lanka	265
Iraq	145
Bangladesh	84
Ireland	73
United States	71
Germany	66

Historically there has been no specific training available for OTDs, and those who are ineligible for the vocational (specialist) registration pathway and are permanent residents have to pass USMLE Steps 1 and 2 and NZREX examinations (see Registration pathways diagram). After passing NZREX there is probationary registration for at least one year before general registration is granted.

In 2000, government funding was made available for a bridging program for a group of OTDs who had immigrated in 1991-1995 under a New Zealand Immigration Service policy when residence was granted without a requirement for the doctor to be either registered or registrable.

To qualify for the bridging program these doctors also had to have graduated from a WHO Directory listed medical school, have a Certificate of Good Standing and pass an approved English test. These doctors are exempt USMLE Steps 1 and 2 if they pass the program but are required to pass NZREX. The first intake was in 2001 with the last scheduled in 2004.

The bridging program has two parts: Part A which is theoretical and medical school based, and Part B which is an observership.

Part A is 4 months and consists of a refresher course (covering medical knowledge, skills, and professional development) and assessment (to end Year 5 medical student standard).

Part B is 6 months and consists of rotations in supervised hospital placements and a supervisor's report.

Apart from this bridging program (which is only for some doctors), no other assistance is given by government or MCNZ to candidates to prepare for NZREX.

Bridging program graduates have tended to do less well at NZREX than non-bridging program candidates. It is difficult to explain the results given the intensive input the candidates receive just prior to sitting the examinations, but it is expected that this may be due to a number of the bridging program candidates not practising for many years. Some doctors had not practised for more than 10 years.

NZREX results

	Pass	Fail	Total (n)	Passed
April 2002				
Bridging	27	16	43	63%
Nonbridging	22	11	33	67%
Oct 2002				
Bridging	25	27	52	48%
Nonbridging	26	13	39	66%
April 2003				
Bridging	21	13	34	62%
Nonbridging	9	5	14	64%
June 2003				
Bridging	5	7	12	42%
Nonbridging	9	8	17	53%

NZREX graduates have probationary registration (Class 2) and go to an approved position (usually at a hospital but also some GP placements) for a minimum 12 months, and a minimum of 1 category A medical and 1 category A surgical runs.

They must have a minimum of 3 consecutive satisfactory quarterly supervisors' reports (if not, the probationary period is extended), and attend educational sessions.

The intern supervisor receives the supervising consultant's report, which is provided quarterly to MCNZ and after 12 months recommends on suitability for general registration. The intern supervisor has a contractual arrangement with the MCNZ.

Unlike the situation for New Zealand trained graduates there is no specific training funding available from government for OTDs in their probationary year.

By the end of the first three months run, 20 out of 22 bridging program graduates from the first cohort consistently met, or were performing above expectations in the five skill sets that all probationers are assessed in. Two doctors performed below standard. The areas where lower ratings were given were clinical knowledge and skills (n=2), clinical judgment (n=2), professional attitudes and behaviours (n=1) and communication and teamwork (n=1). At nine months, all of the first cohort was performing satisfactorily.

Up to 20% of all NZREX graduates have some problems adapting to working in the New Zealand health system. The issues that generally cause concern are communication, English language skills, practical skills and cultural awareness. Managing remedial work depends on the intern supervisor and supervising consultants together with a high level of input from hospital management and RMO coordinators.

A MCNZ survey in 2002 about induction and supervision which included a small number (n=57) of NZREX graduates found that whilst most indicated it was of medium-high importance to be made aware of the cultural issues surrounding living and working in New Zealand, 30% were not satisfied with the information provided. Respondents reported that the following issues restricted their ability to practise:

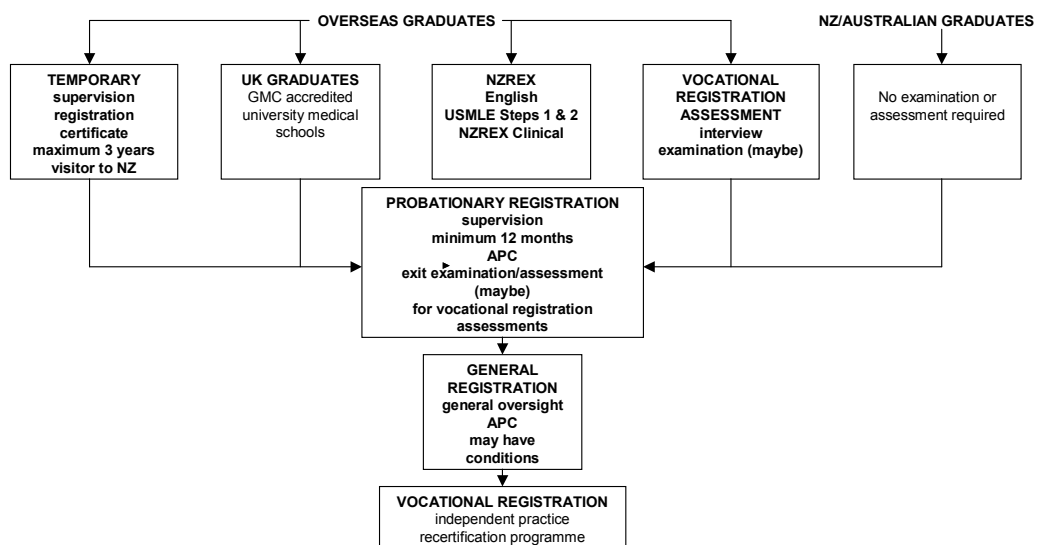
- Excessively long hours (>55/wk)
- Doctor shortage
- High staff turnover
- High case loads
- Lack of resources for effective intervention
- Lack of experience in New Zealand healthcare system
- Insufficient knowledge of medications
- Unfamiliar documentation
- Language and communication

Whilst the first five issues identified are likely to be common to all doctors in New Zealand the others are areas where further work needs to be carried out in order that OTDs are adequately orientated to the New Zealand health system.

For further information see the paper *Ineson S. Overview of the Orientation and Training of Overseas Trained Doctors in relation to the work of the Medical Council of New Zealand. Medical Council of New Zealand, June 2003* distributed as pre-reading material for the workshop.



Registration Pathways



Slide 1

Overseas Trained Doctors: What Is Needed?

Associate Professor Alex Cockram
Chair, Working Party on Overseas Trained Doctors, Medical Training Review Panel, Commonwealth Department of Health and Ageing.
Clinical Director, Illawarra Mental Health Service, NSW.

The MTRP is a group of stakeholders who provide advice on issues related to the training and education of medical practitioners in Australia and the impact of the changes in the provider number legislation to these training and educational needs. It looks at demand for and supply of medical training opportunities and monitors impact of provider number arrangements. A large stakeholder conference on the provider number issue will be held in early 2004.

The MTRP is a statutory committee set up in the Commonwealth Department of Health and Ageing and reports to the Minister.

Membership includes state and commonwealth governments, specialist colleges, doctors in training, medical schools, the Rural Doctors Association, GP divisions, and AMWAC.

In the last year, OTDs have emerged as a group of medical practitioners in Australia that require specific focus at the MTRP.

The objectives of the OTD Working Group include:

- Bring together a variety of stakeholders

- Utilise and assimilate work from a variety of existing projects

- Utilise the expertise of key individuals involved with OTDs (ie to avoid duplication) and make recommendations to the MTRP

The working group will:

- Consider the education and training needs of OTDs

- Consider the needs and difficulties encountered by OTDs, employing organisations and the existing medical workforce

There is a lot of common understanding about what the problems are. The issue is how to find solutions.

What do we need?

- Medical workforce

- Competent medical workforce

- Competent medical workforce to work in the specific setting

- Competent medical workforce to work in the specific setting who can communicate effectively with patients

We need reliable data.

Currently there are multiple data sets that are difficult to cross reference. Unfortunately no one data set captures all OTDs in Australia.

The dataset (in decreasing size of the set):

- Immigration (enter Australia and identify profession)

- AMC (contact for assessment)/ professional colleges

- Medical boards (register as doctors)

Employers (state/territory held databases)

The Immigration data set is thought to be inaccurate, as OTDs have reported that they do not declare their professional standing as it may reduce their immigration rating.

We need transparent processes.

We have complicated and lengthy pathways. There is circularity of relationship between immigration/medical boards and employers. The enormous number of organisations involved make it difficult for an OTD and employers to negotiate the system. The separate medical boards of the states and territories, various state health departments the colleges and rural workforce agencies to list a few.

Financial support for OTDs to access educational opportunities and to cover the costs of relocation need to be addressed. These costs are variably met by employers and the OTDs.

We need valid, reliable and accessible assessments

Is the assessment process accessible?

Does the assessment ensure appropriate competencies to work in Australia? And in what capacity?

Does the assessment ensure the appropriate competencies to supervise others?

Is the assessment consistent between candidates and between medical specialties?

We need to consider the educational and training needs

Communication and language

Cultural issues

Often as part of area of need scheme placed in areas where medical support limited and workload high

Bridging courses

Supervision requirements

Support

Often OTDs move for work, creating family dislocation.

OTDs need realistic expectations of the new community. They need support for their family.

Ethnicity of local area

Rural vs outer metropolitan vs metropolitan. In some instances rural OTDs are more supported by the local community than those placed in outer metropolitan or large regional areas

Define the responsibilities of organisations involved

Impact of OTDs on existing medical workforce - for example, on supervision of junior residents, trainees. Often the burden on junior staff is increased.

Our medical workforce is overstretched. As we have cut back, support has been pared back. Doctors are now expected to do more administrative and clinical tasks.

Education and training support by employers

Responsibilities of professional organisations - colleges, medical boards, medical associations. What can colleges do to reach out and offer support to people who are not yet members?

Preliminary comments

By the end of 2003, with the increased energy and focus currently being generated, we are committed to developing some solutions to these issues

We are considering an Australia wide mandatory basic training program: ie communication, Australian medical system, a basic skills set.

There is a need to define responsibilities of employers in relation to support of OTD, to define responsibilities of professional groups and more accurately define levels of supervision. Supervision needs vary.

A report on the recommendations will go to MTRP in April 2004. It will consider recommendations from this forum and the one in Queensland in November for OTDs.

Dr Norman Swan: What is the power of the panel to get things into action?

Associate Professor Alex Cockram: The MTRP has in the past played a major role in developing new policies in relation to education and training in Australia. The now standard selection guidelines developed by a previous working group under the chairmanship of Dr Brennan are an example.

Question from the floor: Is the AMC reviewing specialist medical colleges through the accreditation process?

Associate Professor Alex Cockram: The AMC has started a cycle of accreditation of the specialist medical colleges. The accreditation process includes a section on OTDs

Dr Norman Swan: Regarding numbers, what is your prediction - we now have a medical workforce shortage, but what of the future?

Associate Professor Alex Cockram: It is not part of our terms of reference of our subcommittee to look at workforce planning.

Mrs Beverley Sutton (Austin and Repatriation Medical Centre): MTRP has been enormously helpful. They recommended a lot of good things we now have in medical education. My concern is the membership you put up. I am increasingly finding that groups which have power in Australia don't include hospital employers.

Associate Professor Alex Cockram: We do have representatives of hospital employers on the OTD subcommittee.

Miss Gabrielle Du Preez-Wilkinson: I wish to disagree with your preference for using the term OTDs rather than IMGs. Using IMGs may take the emphasis away from the fact people were trained overseas and back to what they can do as individuals.

Comment from the floor: Regarding communication, there is much cultural overlay, for example in psychiatry, which would make it difficult for OTDs. It is ironic that many people working in psychiatry are OTDs. It is important for OTDs to be able to communicate with consultants as well as patients.

Associate Professor Alex Cockram (In response to a request for more information about the mandatory training program): We have been canvassing the possibility of a compulsory education program to orientate OTDs to the Australian medical system. It's not

just about medicine, it's about the medical system - for example, what is the PBS? It could be called an orientation/bridging program.

Overseas Trained Doctors: What Is Needed?

Associate Professor,
Alex Cockram.
Chair, MTRP working
group on OTDs.
Illawarra Mental Health
Service, NSW.

Slide 1

Medical Training Review Panel

- Commonwealth Department of Health and Ageing
- Looks at demand for and supply of medical training opportunities and monitors impact of provider number arrangements
- Membership includes State and Commonwealth government, Specialist Colleges, doctors in training, Medical Schools, RDA, GP divisions, AMWAC

Slide 2

Objectives of OTD Working Group

- Bring together a variety of stakeholders
- Utilise and assimilate work from a variety of existing projects
- Utilise the expertise of key individuals involved with OTDs

Slide 3

Objectives of Working Group

- Consider the education and training needs of OTDs
- Consider the needs and difficulties encountered by OTDs, employing organisations and the existing medical workforce
- Provide recommendations to the MTRP

Slide 4

Understanding of the Issues

Many groups have previously and are continuing to accurately define the issues

Slide 5

What Do We Need?

- Medical workforce
- Competent medical workforce
- Competent medical workforce to work in the specific setting
- Competent medical workforce to work in the specific setting who can communicate effectively with patients

Slide 6

Reliable Data

- Definition of OTD:immigration status, using existing definitions of medical workforce
- Currently multiple data sets that are difficult to cross reference

Slide 7

Reliable Data

- In decreasing size of the set;
 - Immigration (enter AU and identify profession)
 - AMC (contact for assessment)/ professional colleges
 - Medical boards (register as doctors)
 - Employers (state/territory held databases)

Slide 8

Transparent Processes

- Complicated and lengthy pathways
- Circularity of relationship between immigration/medical boards and employers
- Financial supports ? and to whom ?

Slide 9

Valid, Reliable and Accessible Assessments

- Is the assessment process accessible?
- Does the assessment ensure appropriate competencies to work in AU? And in what capacity?
- Does the assessment ensure the appropriate competencies to supervise others
- Is the assessment consistent between candidates and between medical specialities?

Slide 10

Consider the Educational and Training needs

- Communication and language
- Cultural issues
- Often as part of area of need scheme placed in areas where medical support limited and workload high
- Bridging courses
- Supervision requirements

Slide 11

Support

- Need realistic expectations of:
 - New community
 - Support for the family
 - Ethnicity of local area
- Rural vs Outermetropolitan vs Metropolitan

Slide 12

Define the Responsibilities of Organisations involved

- Impact of OTDs on existing medical workforce
- Education and training support by employers
- Responsibilities of professional organisations; colleges, medical boards, medical associations.

Side 13

Preliminary Comments

- By the end of 2003 with the increased energy and focus currently being generated we will have developed some solutions

Slide 14

Preliminary Comments

- Accurate data on OTDs
- Up to date national website with appropriate links
- Review assessments and consider the competencies assessed and whether they match the duties of the job

Slide 15

Preliminary Comments

- Consider an Australia wide mandatory basic training program: ie communication, Australian Medical system, basic skills set
- Define responsibilities of employers in relation to support of OTD
- Define responsibilities of professional groups and more accurately define levels of supervision

Slide 16

Future

- Report on recommendations to MTRP April 2004

Slide 17

What training is there in Australia?

Professor Barry McGrath, Chairman, Postgraduate Medical Council of Victoria and OTDs subcommittee; Professor of Medicine, Monash University; Executive member, AMC Committee for Examinations

There are 3,500 permanent resident OTDs registered with the AMC.

About 1,000 PROTDs sit AMC exams annually: 600 pass the written exam and 340 pass clinical exams. These are roughly the same numbers as come from two medical schools.

There are increasing numbers of temporary resident doctors and "area of need" specialists. There were 667 in 1992/93, versus 2,656 in 2001/02.

There are 1,400-1,500 in first year vocational training placements, ie many more people coming in than there are training places.

State reviews of OTD training needs include:

NSW: A pre-employment program for OTDs entering the Australian workforce 1997-9 (Sullivan et al 2002)

Victoria: 'Negotiating the system' (PMCV Dec 2000); 'AMC candidates in Victorian hospitals' (2001-2)

SA: 'Meeting the language and literacy needs of OTDs working in Australia' (CEPTSA June 2001)

Tas: 'Overseas trained doctors in Tasmania' (PGMIT Nov 2001)

WA: PTAC and PMEC assessment/pre-employment (in progress)

Qld: Integrated OTD management proposal (Qld Health 2003)

PMCV Review: AMC candidates in Victorian Public Hospitals (2001-2)

Key questions are:

What are the needs of OTDs which differ from Australian trained graduates?

What is the extent to which needs are being met?

What are the most critical deficiencies?

Which organisations have a role?

How could these deficiencies be addressed?

PMCV Report: AMC candidates in Victorian Public Hospitals (2002)

Country of medical training of 283 AMC candidates working in Victorian hospitals

India	18%
Iraq	18%
China	10%
Sri Lanka	7%
Egypt	5%
Bangladesh	5%
South Africa	4%
Other	(33 countries 1-10)

41% age > 40 years

PMCV Report:

"Overseas trained doctors provide an invaluable service, often in difficult circumstances. In many cases they are recent arrivals and need to cope with settling their

families and themselves to a new country with different language, customs and often a different health system."

PMCV Report: AMC candidates in Victorian Public Hospitals (2002)

Key issues identified by stakeholders (registrars, nurse unit managers and HMO managers):

Significant variability in medical knowledge

Significant variability in clinical skills

Communication difficulties

Almost no matching to previous experience

Increased supervision of new OTDs to ensure patient safety

Recommendations:

Resource and information centre

Web site; online employment register

Clinical and communication skills training

Assessment process prior to registration

Orientation to the Australian Health system

Funded training positions

We received funding from MTRP to do a national scoping study (2003). The objective is to undertake a comprehensive review of resources related to education, training, employment opportunities and ongoing support mechanisms for OTDs in Australia. It is still underway so I can't give results.

Activities undertaken by the study include:

Reference group formed

Survey on education and orientation needs

Literature review undertaken

Telephone and face-to-face interviews

Current education programs reviewed

Available resources reviewed

Questionnaire for OTDs attending NZ Workshop developed

The study has identified the following stakeholders:

Clinical training units in hospitals

Health departments

Rural workforce agencies

Australian Medical Council

Specialist medical colleges

Privately conducted GP training agencies

Medical registration boards

Issues include orientation:

Mandatory orientation programs in all states as part of hospital intern posts

Pre-employment programs - NSW, SA, WA, Qld

Rural workforce initiatives exist in most states. There are some real issues to work out - who recruited and what was the criteria? We have some real problems with some of the area of need appointments processes. There seem to be increasing support mechanisms in the rural sector but less so in the outer metropolitan areas.

Issues include communication:

OTDs have identified their need for assistance

Variability of communication skills is an issue for Australian health professionals

Assessment of communication skills in clinical settings important; communication skills have to be important to patients.

Problems arise in remote settings

Need for communication skills assessment and training for OTDs is a common theme

Many of our courses are moving more towards distance education, moving away from the bedside. OTDs need more contact with patients and opportunities for getting feedback, for example on examination skills, history taking.

Issues include cultural awareness:

Accurate history taking

Understanding the language of the health system

Explaining procedures and diagnoses to patients

Providing information to family members

Discussing cases with consultants, registrars

Communicating with nursing staff

Telephone communication

Handovers

There are no national standard assessment procedures for demonstrating the language proficiency required for medical practice in Australia.

International English Language Training System or Occupational English Test is prerequisite but not sufficient for clinical practice.

AMC examination (MCATs) assesses communication skills.

There are pre-employment programs in NSW, SA, WA, and Qld. There are rural workforce agencies in NSW, Vic, Qld and SA (D4B).

The Victorian Safe Practice Assessment project is to look at 500 doctors a year – a huge task. We are just starting a pilot project involving interview, short examination testing safety and, for those who need it, an OSCE type assessment.

Preparation for exams:

The AMC pathway is sound and respected

Bridging Courses - BOTPLS Scheme User Pays

Privately funded bridging courses have advantages/ disadvantages. They are increasing. There are disadvantages if they move away from the bedside. They may be very popular with OTDs but they will not make them better clinicians.

Support for clinical skills training and upskilling is limited. Supervised training is highly valued by everyone except funding agencies. A review of clinical skills education requirements of Victorian health professionals has been finished and will soon be released. A Canadian study found no literature on the very important area of assessing training needs of teachers for IMGs.

On the job support:

Supervised training in employment highly valued

Directors of Clinical Training & Medical Education Officers (in most states)

Shortage of available medical educators & support

Scope to link OTDs to Divisions of General Practice networks

Main support needs of OTDs:

Streamline information
Stakeholder collaboration
Access to specialist college pathways
Orientation to the Australian healthcare system
Communication skills evaluation and training (in context)
Education and training, upskilling
Skills development and retraining of PROTDS
Education courses for OTDs
Practical experience under supervision
Training scholarships
Medical educators/overseas graduate advisor positions (training and support for supervisors)
Clinical skills education requirements: OTDs in the medical workforce

Clinical skills laboratories have an important and expanding role in health professionals' education. There is a lack of co-ordination, co-operation, and efficient use. There are some good models, eg Liverpool hospital, Sydney.

Simulation Centres

Rapid growth internationally (29 in 1997 to 249 in 2002)
'Clinical Skills Education Requirements of the Health Professions in Victoria' – Report 2003

Barriers to education support programs for OTDs in Australia:

Funding
Lack of coordinated approach by organisations
Lack of mechanisms for stakeholder collaboration
Cultural isolation of many OTDs
Time consuming nature of orientation and education programs for OTDs

Overseas trained doctors in NZ:

'Employers and supervisors have reported that overseas graduates have difficulties in two distinct areas:

1. New Zealand culture - including communication, understanding cultural issues, patient expectations and rights, informed consent, ethical principles, medicolegal framework and working in a multidisciplinary team (especially with female team members)
2. Clinical and practical skills - eg clinical judgement, application of medical knowledge, management of common problems, problem solving and decision making skills, dealing with emergencies and acute work, clinical record keeping, prescription writing, completion of certificates, insertion of intravenous lines.

"Education, training and supervision for new doctors", Medical Council of NZ, 2001

"Close supervision is therefore required to identify the doctor's strengths and weaknesses, to ensure public safety, and to give the doctor a supportive start to his or her career in NZ. Employers are therefore required to provide an appropriate educational environment..."

Overseas trained doctors in the UK:

"In the two years that I have been editor of Careers focus, many overseas doctors have shared their experiences with me. I have felt privileged that they have taken me into their confidence but frustrated that I can't do more to help them. Negotiating the paperwork and procedures is a mammoth task"

Rhona MacDonald Editor, Careers focus BMJ 15.11.02 153-73

A quick guide to working in the UK:

- Induction courses
- Clinical attachments
- Exam preparation and processes
- Advice on CV and interview skills
- Overseas doctors share experiences and give advice

Canada:

- "A Faculty Development Program for teachers of IMGs", Steinert Y, 2003
- Assessing learner needs and establishing mutual goals and expectations
- Evaluating clinical knowledge and skills
- Providing effective feedback
- Promoting patient-centred care
- Teaching communication skills
- Developing a collaborative teacher-learner relationship and designing individually tailored learning programs

Summary:

The Key issues for training of IMGs for practice in Australia

- Co-ordination and consistency at a National level
- Orientation to the Health Care System – macro and microenvironments
- Assessment of medical knowledge and skills pre-employment
- Medical communication skills
- In practice training, supervision and feedback
- Focus on the educators
- What is the capacity of the system? (There is no focus on training needs of IMGs).

Dr Norman Swan: How does your work tie in with Alex's?

Professor Barry McGrath: The scoping study is directly linking in.

Dr Norman Swan: What models of supervision work?

Professor Barry McGrath: A number of highly individually specific programs. But there is the burn out issue. Greg provides the best model at Shepparton.

Dr David Perez (Dunedin Hospital): I support the need for greater inservice training. My experience is that OTDs need that more than bridging and preemployment support. If we did that, we could halve the current 20 per cent fall out rate.

Ms Linsey De Angelis (SA): Why is there a need for a pre-employment exam in the AMC?

Professor Barry McGrath: Many of the people being employed have not yet passed the AMC exam. It's a fair comment (about the burden of an exam). The problem is that the system needs (Workforce) has grown ahead of the assessment processes and capacity.

Associate Professor Alex Cockram: People in different states can enter the workforce at different stages of the AMC process. People are entering the system with very different levels of assessment of their competencies.

A question from the floor: Are there any data comparing the performance of IMGs at different stages versus those who have completed assessment? Is the system successful in its flexibility?

Professor Barry McGrath: There is no comparison. It would be lovely to have but we don't.

Dr Norman Swan: You are very kind, calling chaos flexibility!

What training for OTDs is there in Australia?

Barry McGrath

*Professor of Medicine, Monash University
Chair PMC Victoria & OTDs subcommittee
Member of Executive - AMC Committee for
Examinations*

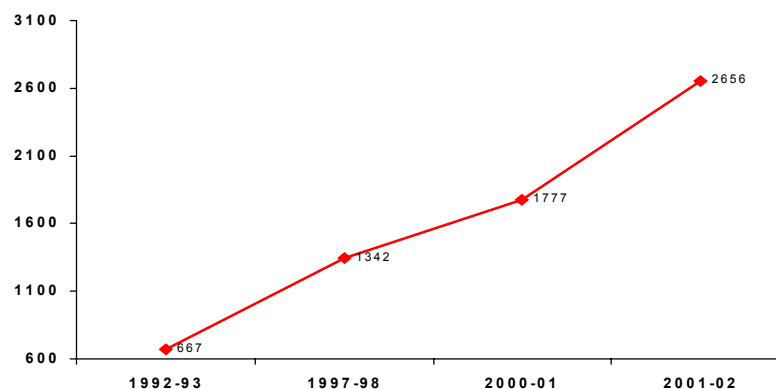
Slide 1

OVERSEAS TRAINED DOCTORS IN AUSTRALIA –The numbers

- 3500 Permanent Resident OTDs registered with AMC
- 1000 PROTDs sit AMC exams annually
 - 600 pass written; 340 pass clinical exams
- Increasing numbers of Temporary Resident Doctors and 'Areas of Need' Specialists

Slide 2

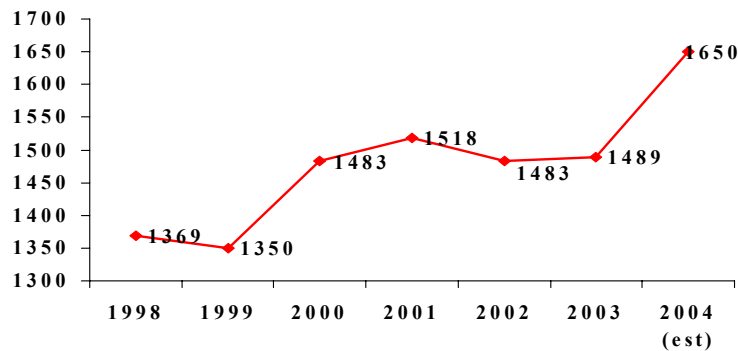
Temporary Resident Doctors arrivals, 1992-2002 (area of need and occupational trainees as at 30 June)



Source: AMWAC & DIMIA

Slide 3

1st year vocational training placements Australia, 1998-2004



Source: AMWAC and Medical Colleges from MTRP Annual Reports

Slide 4

State Reviews of OTD training needs

- **NSW:** A pre-employment program for OTDs entering the Australian workforce 1997-9 (Sullivan et al 2002)
- **Victoria:** 'Negotiating the system' (PMCV Dec 2000); 'AMC candidates in Victorian hospitals' (2001-2)
- **SA:** 'Meeting the language and literacy needs of OTDs working in Australia' (CEPTSA June 2001)
- **Tas:** 'Overseas trained doctors in Tasmania' (PGMIT Nov 2001)
- **WA:** PTAC and PMEC assessment/pre-employment (in progress)
- **Qld:** Integrated OTD management proposal (Qld Health 2003)

Slide 5

PMCV Review: AMC candidates in Victorian Public Hospitals (2001-2)

- **Key questions:**
 - What are the needs of OTDs which differ from Australian trained graduates?
 - What is the extent to which needs are being met?
 - What are the most critical deficiencies?
 - Which organisations have a role?
 - How could these deficiencies be addressed?

Slide 6

PMCV Review: AMC candidates in Victorian Public Hospitals (2001-2)

- Country of medical training of 283 AMC candidates working in Victorian hospitals
 - India 18%
 - Iraq 18%
 - China 10%
 - Sri Lanka 7%
 - Egypt 5%
 - Bangladesh 5%
 - South Africa 4%
 - Other (33 countries 1-10)

- 41% age > 40 years

Slide 7

PMCV Review: AMC candidates in Victorian Public Hospitals (2001-2)

‘Overseas trained doctors ..provide an invaluable service, often in difficult circumstances. In many cases they are recent arrivals and need to cope with settling their families and themselves to a new country with different language, customs and often a different health system.’

Slide 8

PMCV Review: AMC candidates in Victorian Public Hospitals (2001-2)

- Key issues identified by stakeholders (Registrars, Nurse Unit Managers and HMO managers)
 - Significant variability in medical knowledge
 - Significant variability in clinical skills
 - Communication difficulties
 - Almost no matching to previous experience
 - Increased supervision of new OTDs to ensure patient safety

Slide 9

*PMCV Review: AMC candidates in
Victorian Public Hospitals (2001-2)*

■ **Recommendations**

- *Resource and information centre*
- *Website; online employment register*
- *Clinical and communication skills training*
- *Assessment process prior to registration*
- *Orientation to the Australian Health system*
- *Funded training positions*

Slide 10

NATIONAL SCOPING STUDY (2003)

Objective

- *Undertake a comprehensive review of resources related to education, training, employment opportunities and on-going support mechanisms for OTDs in Australia*

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NATIONAL SCOPING STUDY

Activities undertaken:

- *Reference group formed*
- *Survey on education and orientation needs*
- *Literature review undertaken*
- *Telephone and face-to-face interviews*
- *Current education programs reviewed*
- *Available resources reviewed*
- *Questionnaire for OTDs attending NZ Workshop developed*

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NATIONAL SCOPING STUDY (2003)

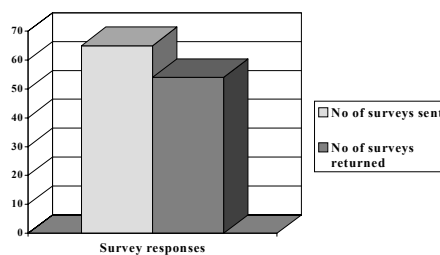
Stakeholders identified:

- *Clinical Training Units in Hospitals*
- *Health Departments*
- *Rural Workforce Agencies*
- *Australian Medical Council*
- *Specialist Medical Colleges*
- *Privately conducted GP Training Agencies*
- *Medical Registration Boards*
- *Health Departments*

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NATIONAL SCOPING STUDY

Survey on education and orientation programs: response rate 86%



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ORIENTATION

- *Mandatory orientation programs in all states as part of hospital intern posts*
- *Pre-employment programs – NSW, SA, WA, Qld*
- *Rural Workforce initiatives – most states*
- *Rural Clinical Observerships – NSW & NT*
- *Professional orientation to medical practice – Medical Practitioners Board Victoria*

Slide 15

COMMUNICATION

- *OTDs have identified their need for assistance*
- *Variability of communication skills is an issue for Australian health professionals*
- *Assessment of communication skills in clinical settings important*
- *Problems arise in remote settings*

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Communication

- *Need for communication skills assessment and training for OTDs is a common theme*
 - **Cultural awareness**
 - **Accurate history taking**
 - **Understanding the language of the health system**
 - **Explaining procedures and diagnoses to patients**
 - **Providing information to family members**
 - **Discussing cases with consultants, registrars**
 - **Communicating with nursing staff**
 - **Telephone communication**
 - **Handovers**

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Communication

- *There are no national standard assessment procedures for demonstrating the language proficiency required for medical practice in Australia*
- *International English Language Training System or Occupational English Test is prerequisite but not sufficient for clinical practice*
- *AMC examination (MCATs) assesses communication skills*

Slide 18

PRE-EMPLOYMENT ASSESSMENT

- *Pre-employment programs - NSW, SA, WA, Qld*
- *Safe practice assessment project - Vic*
- *Rural Workforce Agencies – NSW, Vic, Qld (D4B)*

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PREPARATION FOR EXAMS

- *The AMC pathway is sound and respected*
- *Bridging Courses - BOTLS Scheme User Pays*
- *Privately funded Bridging Courses advantages/ disadvantages*
- *Support for clinical skills training and upskilling is limited*

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ON THE JOB SUPPORT

- *Supervised training in employment highly valued*
- *Directors of Clinical Training & Medical Education Officers (in most states)*
- *Shortage of available medical educators & support*
- *Scope to link OTDs to Divisions of General Practice networks*

Main support needs of OTDs

- **Streamline information**
- **Stakeholder collaboration**
- **Access to Specialist College pathways**
- **Orientation to the Australian healthcare system**
- **Communication skills evaluation and training (in context)**

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Main support needs of OTDs

- **Education and training, upskilling**
 - **Skills development and retraining of PROTDS**
 - **Education courses for OTDs**
 - **Practical experience under supervision**
 - **Training scholarships**
 - **Medical educators/Overseas Graduate Advisor positions (Training and support for supervisors)**

Slide 23

Clinical Skills Education Requirements: OTDs in the medical workforce

- **Clinical Skills laboratories**
 - **Important and expanding role in health professionals education**
 - **Lack of coordination, cooperation, efficient use**
 - **Some good models – Liverpool hospital Sydney**
- **Simulation Centres**
 - **Rapid growth internationally (29 in 1997 to 249 in 2002)**
- **'Clinical Skills Education Requirements of the Health Professions in Victoria' – Report 2003**

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Barriers to education support programs for OTDs in Australia

- **Funding**
- **Lack of coordinated approach by organisations**
- **Lack of mechanisms for stakeholder collaboration**
- **Cultural isolation of many OTDs**
- **Time consuming nature of orientation and education programs for OTDs**

Slide 25

Overseas trained doctors in NZ

- *'Employers and supervisors have reported that overseas graduates have difficulties in two distinct areas...*
 - *New Zealand culture- including communication, understanding cultural issues, patient expectations and rights, informed consent, ethical principles, medicolegal framework and working in a multidisciplinary team (especially with female team members)*

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Overseas trained doctors in NZ

- *Clinical and practical skills- e.g. clinical judgement, application of medical knowledge, management of common problems, problem solving and decision making skills, dealing with emergencies and acute work, clinical record keeping, prescription writing, completion of certificates, insertion of intravenous lines'*

*Education, training and supervision for new doctors.
Medical Council of NZ 2001*

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Overseas trained doctors in NZ

- *'Close supervision is therefore required to identify the doctor's strengths and weaknesses, to ensure public safety, and to give the doctor a supportive start to his or her career in NZ.'*
- *Employers are therefore required to provide an appropriate educational environment...'*

*Education, training and supervision for new doctors.
Medical Council of NZ 2001*

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Overseas trained doctors in the UK

- *'In the two years that I have been editor of Careers focus, many overseas doctors have shared their experiences with me. I have felt privileged that they have taken me into their confidence but frustrated that I can't do more to help them. Negotiating the paperwork and proceduresis a mammoth task'*

Rhona MacDonald Editor, Careers focus BMJ 15.11.02 153-73

- *A quick guide to working in the UK*
- *Induction courses*
- *Clinical attachments*
- *Exam preparation and processes*
- *Advice on CV and interview skills*
- *Overseas doctors share experiences and give advice*

Slide 29

Canada: 'A Faculty Development Program for teachers of IMGs'

- A. ASSESSING LEARNER NEEDS AND ESTABLISHING MUTUAL GOALS AND EXPECTATIONS**
- B. EVALUATING CLINICAL KNOWLEDGE AND SKILLS**
- C. PROVIDING EFFECTIVE FEEDBACK**
- D. PROMOTING PATIENT - CENTRED CARE**
- E. TEACHING COMMUNICATION SKILLS**
- F. DEVELOPING A COLLABORATIVE TEACHER-LEARNER RELATIONSHIP AND DESIGNING INDIVIDUALLY TAILORED LEARNING PROGRAMS**

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Slide 30

Training of IMGs for Practice in Australia: Key Issues

- *Coordination and consistency*
- *Orientation to Health Care System- macro and micro environments*
- *Assessment of medical knowledge and skills*
- *Medical communication skills*
- *In practice training, supervision and feedback*
- *Focus on the educators*
- *What is the capacity of the system?*

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"New Zealand: what's working, what's not working. What needs to stop, what needs to start"

Ms Sue Ineson, Chief Executive Officer, Medical Council of NZ

The Medical Council of New Zealand has a simpler brief than some of the organisations represented at the workshop. Our main *raison d'être* is public health and safety. The Council sets the standard for the entry exam, accreditation of specialist bodies and performs many of the functions of the state medical boards registering doctors, address doctors competence and handle some complaints regarding doctors, and have an overview of PGY 1 and 2.

What is working?

- * The pathway to registration including probationary period helps the Council to monitor doctors, to identify and solve problems.
- * The move to a competency based entry examination is a step forward.
- * The Council increased emphasis on good communication. While the Council looks at all doctors' communication skills this is a reoccurring problem area for overseas trained doctors.
- * The development of Education Handbook and new supervision guidelines make the requirements of the Council much more explicit.

What is not working?

- * The use of temporary registration for very short periods (20% for less than 12 weeks) is a use of energy and resources.
- * Prejudice and concern that hospitals can only absorb so many OTDs at any one time can lead to employment difficulties for OTDs.
- * The lack of mobility of some OTDs can be an issue as many prefer to live in Auckland, perhaps because of the climate and cultural attractions of this city.
- * The quality of supervision is uneven, as a recent survey found 10-20 percent of those being supervised felt their supervision was not adequate.

What needs starting?

- * There is a real need for a "ready for work" program, after the doctors have passed NZREX. This needs funding. It needs to be broad-based, flexible and adaptable to overseas trained doctors needs and give hands on experience to give OTDs confidence to work in our system.
 - * **New Zealand needs intern supervisor posts specifically for overseas trained doctors. It is ironic there is no funding for intern supervisors OTDs who need more assistance.**
- * We need training in cultural competence partly to address Maori health needs and poor health status but also need to make all health practitioners aware of these needs. As well as this, New Zealand is increasingly multicultural and all NZ doctors will have to deal with people from other cultures and need to be culturally aware. This is needed specifically for OTDs so they can learn how NZ operates - such as our approach to gender and end-of-life issues.
- * Increased international coordination is needed in the area of screening examinations. Jurisdictions throughout the world are all running similar examinations, we could decrease this duplication of effort.

- * Career counselling is needed for those who cannot re-enter medicine. Some overseas trained doctors will never pass the examination or enter their chosen career. We need people to assist them to find meaningful alternative careers.
- * The Medical Council will be using the new Health Practitioners Competence Assurance Act to ensure registration systems are more transparent. Policy parameters will be extended and pathways simplified.

What needs stopping?

- * The current bridging program, once current courses completed, should be replaced by a 'ready for work' program.
- * We need good, accurate reporting in the probationary year.
- * There are very few remedial opportunities for people who are struggling in the probationary period. New Zealand has an obligation (40% of NZ doctors are OTDs) to ensure these doctors can fit into our system as soon as possible.
- * Overseas trained doctors also have an obligation to New Zealand. Only by understanding this system can they help to meet the needs of NZ people.

Comment from the floor: There was recently an increase in NZ graduates, but we will still be short of doctors as many NZ graduates leave here.

Dr Norman Swan: How will you get cultural competency into the system as a whole?

Ms Sue Ineson: At the moment we are doing a literature review and scoping study, then the Council will require cultural competence as part of recertification. Through Council accreditation of College programs Council can make sure doctors do learning in this area.

Dr Indraka Fernando (NZ Overseas Doctors Association): Regarding lack of mobility, our members have not refused offers from outside Auckland.

Dr Nadeem Khaja (Hawke's Bay Hospital, Hastings): Bridging programs have changed the lives of many, my wife is working in Middlemore Hospital and my family is in Auckland. I see less of my family, despite what you say there is a lot of mobility and acceptance by overseas trained doctors that they need to move and to sacrifice their families.

Ms Sue Ineson: We worked very hard at the Medical Council to get the bridging program going. But most of the doctors who were entitled to get into that program have now finished it. We need to apply the funding in areas where it is needed now.

Comment from the floor: We have a bridging course in Sydney which has had 700 go through it. The pass rate is 50%, better than people who don't do it.

Question from the floor: When overseas trained doctors have postgraduate qualifications from their own country, what measures can you take to let them get into a training program so they can practise in their own chosen field or specialty?

Ms Sue Ineson: At present many college training programs are not full and the Medical Council has worked with the colleges to try to improve access to training for overseas trained doctors.

Ms Sue Ineson: I agree, I also know of many examples of overseas trained doctors who do move to ensure they can get work.

Dr Susan Hawken, (University of Auckland): If applicants' English standard was higher, then their pass rate would be higher, this should be looked at seriously if the program is being changed.

Dr David Spriggs (Auckland District Health Board/MCNZ): Many overseas trained doctors are frustrated with the multiple assessments before they even get the first house officer job, is this fair and reasonable?

Ms Sue Ineson: Probably not. With the new Act the Medical Council will have a chance to look again at registration requirements and pathways to registration – for example, currently there are 23 different classes of registration in NZ, which is too complex. The changes to NZREX to competency based should also help.



Training & Education of Overseas Trained Doctors

Medical Council of New Zealand

Sue Ineson, CEO

6-7 August 2003

Slide 1



What is working?

- Pathway to registration including probationary period
- Move to competency based entry examination
- Increased emphasis on good communication
- Development of Education Handbook and supervision guidelines

Slide 2



What is not?

- Use of temporary registration for very short periods (20% for less than 12 weeks).
- Employment difficulties for overseas trained doctors.
- Lack of mobility of some overseas trained doctors.
- Supervision uneven.

Slide 3



What needs starting?

- “Ready for work” programme.
- Intern supervisor posts specifically for overseas trained doctors.
- Training in cultural competence education.
- Increased international coordination in area of screening exams.
- Career counselling for those who cannot re-enter medicine.

Slide 4



What needs starting? Contd

- Use of Health Practitioners Competence Assurance Bill to ensure
 - registration systems fair
 - policy parameters extended.
 - pathways simplified.

Slide 5



What needs stopping?

- Bridging programme once current courses completed.
- Inaccurate reporting in probationary year.

Slide 6

Australia: what's working, what's not working? What needs stopping, what needs starting?

Mr Ian Frank, Executive Officer, Australian Medical Council

Many of the issues have been identified for a long time. In Australia, there are many pathways for OTDs to get registration. For the majority of OTDs, the AMC examination is the only pathway for non-specialist registration.

National exams were introduced in 1978. Since then, 7,431 OTDs commenced exams and 3,800 have completed them and qualified for registration.

There have been dozens of reviews at the federal, state and organisational level (the first in 1983). It is sad that 20 years later, we are still identifying the same issues.

Much of the debate has been driven by perception and opinion rather than hard data, which has stopped progress.

There are widely held misconceptions about the AMC examination.

One myth is that the AMC exam is a workforce control as evidenced by the variable pass rates and is biased in favour of UK graduates. Between 1998 and 2002, the pass rate for the AMC MCQ examination has varied between 38% and 66%. However, it should be noted that Canadian pass rates in their first stage MCQ examination for OTDs also vary from 40% to 80%.

COMPARISON OF PERFORMANCE IN MCQ EXAMINATIONS

AMC AND THE MEDICAL COUNCIL OF CANADA

AMC Examinations				Medical Council of Canada Evaluating Examinations			
Exam Series	No. Sitting	No. Passing	% Pass Rate	Exam Series	No. Sitting	No. Passing	% Pass Rate
1998 A	222	88	39.6%	1998 1	705	353	50.0%
1998 B	318	175	55.0%	1998 2	737	372	50.5%
1999 A	351	196	55.8%	1999 1	833	414	49.7%
1999 B	335	129	38.5%	1999 2	866	501	57.9%
2000 A	434	175	40.3%	2000 1	925	431	46.6%
2000 B	517	344	66.5%	2000 2	1,195	751	62.8%
2001 A	531	280	52.7%	2001 1	1,108	679	61.3%
2001 B	450	268	59.8%	2001 2	1,239	768	62.0%
				2001 3	227	119	52.4%
2002 A	434	231	53.2%	2002 1	390	288	73.9%
2002B	437	259	59.2%	2002 2	1,038	598	58.1%
				2002 3	606	419	69.1%
				2002 4	43	35	81.4%
				2002 5	935	583	62.4%

In respect to UK graduates an analysis of the top ten ranked candidates in the last five AMC examinations are not predominantly UK graduates, as the following Table indicates.

MCQ CANDIDATES RANKED 1 – 10 [Merit Order]

By Country of Training, Percentage Overall Score Correct and Age at Time of Examination

Ranking	2001 A		2001 B		2002 A		2002 B		2003 A	
1	Sri Lanka		Iraq		Egypt		India		India	
	83%	36	88%	25	84%	45	91%	24	91%	28
2	India		China		Iraq		India		India	
	81%	28	87%	28	83%	41	90%	26	86%	32
3	Bangladesh		Bangladesh		Iraq		India		Bangladesh	
	81%	45	86%	33	83%	41	90%	25	86%	42
4	Nepal		Iraq		Sri Lanka		Sri Lanka		Yugoslavia	
	81%	27	86%	36	83%	31	89%	36	85%	41
5	Iran		Sri Lanka		Iraq		Bangladesh		Bangladesh	
	80%	39	86%	37	82%	32	88%	35	84%	48
6	Myanmar		Iraq		UK		Iran		India	
	80%	34	86%	31	81%	31	88%	35	84%	25
7	Myanmar		Bangladesh		India		Poland		India	
	79%	35	86%	35	81%	30	88%	35	84%	31
8	Sri Lanka		Bangladesh		Bangladesh		Egypt		India	
	79%	48	85%	34	80%	37	87%	34	83%	34
9	Bangladesh		South Korea		UK		Egypt		India	
	79%	41	84%	37	80%	28	87%	40	83%	30
10	Bangladesh		Iraq		China		Bangladesh		USSR	
	79%	36	84%	33	80%	33	87%	32	83%	38

Other myths are that the exam is too theoretical and doesn't reflect real clinical practice, or that it is too specialised, and that locally trained doctors couldn't answer the questions. (Mr Frank gave examples of several exam questions to refute such views.)

There is a strong correlation in AMC exams between the theoretical and clinical aspects, reflecting deficiencies in the knowledge base. This needs to be considered in bridging programs.

The relevant data for the AMC examination is as follows:

- Between 1978 and 2002 - 7,431 OTDs presented for the national examinations.
- 5,734 - 77.17% of the total - passed the MCQ.
- 4,459 went on to attempt the clinical exam - 3859 or 86.52% of those who attempted clinical exam - passed and qualified for registration in Australia.
- The candidates represent 111 countries of training.
- The age profile of candidates ranges from 24 years to 65+ years with a mean of 30 – 34 years.
- 57% of candidates who pass are less than 34.

The performance data indicates that 80% of candidates who pass do so within their first two attempts. If they haven't passed after two attempts, there is a strong probability they will not pass unless there is a significant change in their circumstances, such as attendance at a bridging course.

There have been major changes to the clinical exam since it was implemented in 1978. The most recent significant change was in 1997 when communication and consulting skills were introduced as part of the exam.

In summary the changes to the clinical examination have been as follows:

Pre-1997 clinical exam modelled on final MBBS exams:

Medicine short cases / Viva

Surgery short cases / Viva

O & G long case and Viva

1997 – 2001:

Medicine short cases

Surgery short cases

Medicine & surgery consulting skills

O & G/Paediatrics consulting skills

2001 – 2003: Two stage format, to make it more structured.

Stage 1: Medicine & surgery consulting skills [74.77% pass rate]

O&G consulting skills [68.6% pass rate]

Paediatrics consulting skills [74.7% pass rate]

Stage 2: 12 station medicine & surgery OSCE [94.6% pass rate]

In stage 1 clinical exam, the O&G component represents the major obstacle for candidates passing the exam.

A 1983 review by the Commonwealth (Fry) identified 4 categories of OTDs:

I. with similar medical training and practice background – high pass rate

II. moderately different – high ability – high pass rate

III. different practice background – need short reorientation to pass

IV. significantly different practice background – need substantial re-training and reorientation of skills to enter medical workforce in Australia

[Recognition of Overseas Qualifications in Australia (Fry Committee) 1983]

The review differentiated between those who needed short orientation and significant retraining to pass the exam, ie one form of training didn't fit all. There is not one class of OTDs.

Subsequent studies (including the 1999 ARTD report for the Commonwealth) lead to more complete data and have refined the categories. Anybody working with bridging programs should read this report. However, it should be noted that this study concentrates on getting candidates through the exam rather than integration of OTDs into the workforce.

Information Issues

What works?

The most significant change in the last 15 years has been in the quality and quantity of information available to OTDs.

Pre-1989 only minimal information was available regarding the exam. There was no guidance on content or exam preparation, and minimal feedback on performance (they were told only if they had passed or failed a subject).

A wide range of information is now available from a variety of sources including:

- Exam specifications booklets. AMC exam publications, including a book on clinical problem solving which helps candidates and may be useful to bridging courses
- Clinical examination videos

- An AMC web site which gets about 10,000 hits per month.

In addition, the AMC notifies all candidates registered with the Council of important changes to examination formats or requirements in writing.

But no amount of printed information is sufficient of itself. We need to supplement existing information with face to face briefings.

The NSW Department of Health has run a briefing session since 1998 which has lead to a reduction in heat on the AMC from callers. I would recommend other jurisdictions put in place similar briefings.

What doesn't work?

Counseling of failed candidates has been the least successful initiative. A number of factors contribute to this lack of success:

- Many of those who fail are older candidates and may have been out of medical study and practice for many years.
- Many candidates had high status in their own countries and are reluctant to acknowledge failure.
- 52% of females and 41% of males pass leading to difficulties with some male candidates acknowledging their deficiencies. There can be problems when the wife passes and the husband fails.
- 57% of those who pass are under 35 which again has caused problems for some older candidates in counseling sessions.
- There is a lack of remedial opportunities. We can pinpoint the problems an individual has got but there is nowhere to send them. If they are in a current clinical post, there is more chance they will take feedback on board.
- Lack of insight is one of the things that leads candidates into difficulties in the clinical exam. If they are not aware of the limitations of their knowledge, it can be very difficult.
- If people are under stress, they become egocentric and may not take feedback on board.

Although the AMC efforts in counseling have not been successful, that is not to say counseling will not work. There is evidence of successful counseling of AMC candidates, where the counseling has been undertaken in a non-threatening environment such as a bridging course.

What needs stopping?

Alternative career counseling after the event for long term unsuccessful candidates. It is not surprising that people are reluctant to take it on board. An alternative approach would be to consider the Canadian experience with pre-exam allied health positions. Canada puts OTDs into clinical assistant roles so they can get into the system. Perhaps we need to look at utilizing such positions at the front end, and not the rear end of the process after a difficult exam.

Bridging Courses

The success of bridging courses has been seen as a "given". There was a plethora of them in the early 90s getting lots of funding. The intermittent funding of programs by successive government has lead to variable results.

The AMC is not informed of the participation rates of candidates in bridging courses. However, the limited studies that have been undertaken suggest the pass rate for bridging program candidates is variable. But these are studies based on small numbers and may not be representative.

An independent study of comprehensive data [ARTD 1999 Study on Bridging Courses] found:

"At the broadest level, the candidate pass rate of clinical bridging course participants is not significantly higher than the pass rates of candidates who have not completed a bridging course."

But bridging courses do more than get people through an exam. Anecdotal evidence from the early 90s showed that bridging program candidates were more confident in dealing with patients. There is a need to recognise the diversity of OTDs and tailor assessment systems and re-training programs to reflect this diversity. One size does not fit all.

There is a need to recognise the distinction between orientation, bridging and retraining. Bridging programs will not help those who need retraining. Virtually all candidates coming to Australia need some orientation. Where possible, we should integrate assessment for registration with bridging/retraining. It was not possible to implement in the past but we may have the systems to do this now.

The Challenge

We need to think outside the square. There are not sufficient resources to meet the current demand for bridging and retraining. We haven't got the funds for a bicycle, never mind a Rolls Royce approach. We need to share information locally, nationally and internationally, and to look at what works elsewhere, and to think of smarter ways of working.

For example, the Canadians spent ten years developing a blueprint for their licensing examination which could also assist OTDs preparing for the exams. The AMC has undertaken a joint venture with the Canadians which has allowed us to take their publication and revised it for the Australian scene. In 12 months, we have turned a manuscript into a book. This project could not have been undertaken with the limited resources available in Australia.

We need smarter solutions or we will still be discussing this in 20 years time and that would be a terrible waste.

Another example would be to stream OTDS into different track for assessment. The ATRD report identified people who may need minimal assistance to enter the medical workforce. If we can find a way of distinguishing them - why hold them up in a long process?

There will be some changes to the exam - next year we are doing 800 clinical exams. If we could separate out the top from the bottom candidates, it would free up resources for the larger middle group.

Dr Norman Swan: What about front end assessment?

Mr Ian Frank: It is expensive and lengthy to do pen and paper exams but computer exams could be done more often and run externally - before they leave their country. There is a move by many countries for greater international consistency.

A question from the floor: In Canada, Canadian and overseas graduates sit the same licensing exams. Is there room to expand exams?

Mr Ian Frank: There would be no support educationally for a national licensing examination in Australia.

(In response to a question from the floor regarding specialist pathways):

All colleges since 1993 have had a pathway separate from the AMC to evaluate. If they say, you need more than two years of further training, you have to go back and sit the AMC examination. The problem is that the assessments differ because different colleges have different processes and requirements. A recent report by the ACCC requiring the RACS to do a public review will have a spin off effect on all colleges. It must report in nine months.

Ms Gabrielle Du Preez-Wilkinson: I agree that the bridging program is not just about how to pass the exam. Many have said that they learnt from it how to be better doctors. We tried to have a clinical assistants program in Qld in the mid 90s. It was a failure. The JMOs baulked and said they couldn't do it because it increased their workload because of having to double check the

work of the clinical assistants. You may have to do the counselling at the front end rather than at the rear end.

Mr Ian Frank: There has been a huge increase in temporary resident doctors. It may not be the answer but there may be ways of doing something at the start rather than at the end of the process. We need someone to pilot it and to learn from the mistakes. It may not have an answer for today or tomorrow but for down the track.

A question from the floor: The skilled medical education workforce in Australia is limited. What is the potential for working with hospitals and universities?

Mr Ian Frank: The system over the years has encouraged innovation and alternative approaches in medical education. We should encourage people to look at alternative ways of doing things and discuss them - not to say there is only one way of doing things.

Comment from the floor: There is a conflict between that and what Alex is saying about a national approach.

Mr Ian Frank: We may need both national and local focus.

Dr Hubertus Jersmann (University of Adelaide): I may be able to explain why is there seeming inconsistency regarding the results of the bridging program. Categories 1 and 2 are least likely to do the bridging course. In other words you are not using the right control group for comparing results.

Mr Ian Frank: The programs wanted to show they worked, so pre-screened candidates. The bulk of the people who needed the training weren't being selected into the bridging programs.

Comment from the floor: Surely we want competent, capable, confident doctors? The MBBS alone in Australia doesn't produce that. We set some further standards. We are missing a critical assessment of OTDs, to work out which is the most appropriate pathway for OTDs.

Mr Ian Frank: I agree but if we haven't got the resources to develop a sophisticated tool to do that, we may need to use what we have.

Dr Talal Baaj, The Queen Elizabeth Hospital, SA: The MCQ is not a good assessment for the examination. After I passed my MCQ, I was employed at the Queen Elizabeth Hospital and did a full year internship. I have very good assessments for the following year but couldn't satisfy a clinical examiner, who I didn't know, in a 15 minute exam. The AMC don't work closely or give attention to the difficulties for OTDs and the hardships we have, especially financial and family stresses. Regarding the need to counsel OTDs to other pathways, I repeated the MCQ three times. It was financially very difficult. I worked in aged care. Difficulties with the cost lead to a longer delay and more skills being lost.

Mr Ian Frank: I agree. The AMC is limited in its scope. It's not chartered to provide any bridging or other support but is conscious of the issue, hence our production of the two books. The changes next year aim to cut down the delay and reduce the cost of the exam but the AMC has resource constraints. The 1988 Doherty report recommended all candidates who passed the MCQ exam should do a bridging course before the clinical exam. However, the numbers of candidates has increased substantially since then and the option is no longer viable.

Dr Lynn Robinson, Med-E-Serve: There is a need to look at what other professions/sectors do with this issue. Given the difficulty that governments tend to have with capital investment, is there a role for the private sector to raise capital and put in place infrastructure to be provided as services?

Mr Ian Frank: It may be an answer but there are still teething problems regarding the university role. Regarding private sector, how will it be paid? By governments/candidates? I can not say what happens in other areas.

Dr Patricia Molloy, Medical Practitioners' Board of Victoria: We are doing close analysis of performance to see correlations between MCQ and subsequent performance, to see if the process could be streamlined. This would be a more effective use of resources but may not get up because we need to get support from others.

Professor John Campbell (MCNZ): The hard core of 20% who are failing may have problems which can't be corrected through any retraining program. There is an obligation to identify them early, especially before they enter the workforce.

Mr Ian Frank: There is some data available from Canada, which has developed an assessment process for doctors with sub optimal performance. They reported problems when these doctors were taken out of practice and put into remedial programs but showed no improvement in performance. The Canadian studies indicated that the unsuccessful doctors had cognitive deficiencies that couldn't be fixed by the available remedial programs.

An AMC graduate: How much does the AMC exam assess the clinical skills of the doctors? 60-70% of questions were repeated from past papers. The three friends and I who studied the old papers all got the same marks. Just going through the previous ten years worth of papers increases the chances of passing. It was difficult for doctors who had specialised previously.

Mr Ian Frank: The AMC exam doesn't aim to assess you as a specialist but to work in any field, because the registration is unconditional.

An AMA representative: We have had difficulty getting the OTD voice in the AMA. Does the AMC know of any OTD groups? Many of the frustrations of these candidates is because they are not consulted. Is the AMC actively consulting?

Mr Ian Frank: It is difficult to identify spokespeople. There are many different groups and no single voice. We meet and liaise with these groups. NSW Health briefings also provide feedback which is built into our process. Regarding doctors in training, the AMC is now accrediting specialist training which includes anonymous surveys of trainees, producing interesting results. Trainees are on the accreditation committees, they have a voice in the process.

**Medical Council of New Zealand
Confederation of Postgraduate Medical Education
Councils
Workshop**

- **What is Working?**
- **What is not Working?**
- **What Needs Starting?**
- **What Needs Stopping?**

The Australian Medical Council Perspective

Ian Frank
AMC Executive Officer

Education and Training for Overseas Trained Doctors Workshop
Wellington, New Zealand, 6-8 August 2003

Slide 1

Overview

- ▼ **A number of options for OTDs to obtain registration in Australia**
- ▼ **For majority of OTDs AMC examination only pathway for non-specialist registration**
- ▼ **Since 1978 7.5k OTDs commenced exams**
- ▼ **3.8k completed and qualified for registration**
- ▼ **A dozen reviews in 25 years with mixed results**
- ▼ **Contributing factor to lack of success of some initiatives reliance of myth, rumour and legend rather than factual data**

Education and Training for Overseas Trained Doctors Workshop
Wellington, New Zealand, 6-8 August 2003

Slide 2

Overview

- ▼ **Examine popular misconceptions**
- ▼ **Attempt to profile OTDs based on performance at AMC exam**
- ▼ **Explore the effectiveness of 3 strategies:**
 - **The provision of information**
 - **Counselling and feedback**
 - **Bridging Courses**

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Slide 3

Myths Rumours & Legends

- ▼ **Myth 1: The AMC exam is a workforce control as evidenced by the variable pass rates.**
- ▼ **Myth 2: The exam is too theoretical and does not reflect real clinical scenarios.**
- ▼ **Myth 3: The AMC exam is too specialised and does reflect intern standards.**
- ▼ **Myth 4: Locally trained doctors would not be able to answer questions presented in the AMC exam.**
- ▼ **Myth 5: The AMC exam is biased in favour of UK grads at the expense of graduates from non-English speaking and developing countries.**

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Slide 4

COMPARISON OF PERFORMANCE IN MCQ EXAMINATIONS AMC AND THE MEDICAL COUNCIL OF CANADA

AMC Examinations			
Exam Series	No. Sitting	No Passing	% Pass Rate
1998 A	222	88	39.6%
1998 B	318	175	55.0%
1999 A	351	196	55.8%
1999 B	335	129	38.5%
2000 A	434	175	40.3%
2000 B	517	344	66.5%
2001 A	531	280	52.7%
2001 B	450	268	59.8%
2002 A	434	231	53.2%
2002B	437	259	59.2%

Medical Council of Canada Evaluating Examinations			
Exam Series	No. Sitting	No. Passing	Percentage Pass Rate
1998 1	705	353	50.0%
1998 2	737	372	50.5%
1999 1	833	414	49.7%
1999 2	866	501	57.9%
2000 1	925	431	46.6%
2000 2	1,195	751	62.8%
2001 1	1,108	679	61.3%
2001 2	1,239	768	62.0%
2001 3	227	119	52.4%
2002 1	390	288	73.9%
2002 2	1,038	598	58.1%
2002 3	606	419	69.1%
2002 4	43	35	81.4%
2002 5	935	583	62.4%

Slide 5

Multiple Choice Question Bank

ARCHIVED

Confidential



Bank No.: 481 Type: A Flagged: N Mastery: Y Pilot: N
Source: UPDATED 6/90 OG - Obstetrics & Gynecology

Function: D - Diagnosis and Investigations

System: 9 - Reproductive System (Male/Female)

Condition: MANAGEMENT OF PRIMARY POST-PARTUM HAEMORRHAGE.

Stem

The FIRST STEP in treating a post-partum haemorrhage of 750ml 20 minutes following delivery of the placenta SHOULD BE TO

Responses

Correct Response

- | | | |
|---------------------------------------|---|-----|
| A | inspect the placenta to make sure it is complete. | No |
| B | empty the bladder by catheterisation. | No |
| <input checked="" type="checkbox"/> C | give ergometrine 0.25mg intravenously. | Yes |
| D | cross-match blood. | No |
| E | inspect the cervix for laceration. | No |

Statistics (most recent)

Sqn	Response	Exam Date	Series	%	Biserial	Flag	Dist.	Mean Ab.	Comments
103	*	14/10/1997	B	19.9	-0.02			N/A	

Flags:

Illustrations:

Notes: RESPONSE 3 MODIFIED PROF PEPPERELL JULY 1997.
VIEWED AND CONFIRMED PROF PEPPERELL DECEMBER 1999.
EXCLUDE FROM USE. THIS IS WORSE AFTER MODIFICATION. PROF PEPPERELL REQUESTED
THAT THIS QUESTION NOT BE RE-USED - ARCHIVED JANUARY 2001.

Slide 6



I-0064

Bank No: 4525

Type: J

Stem: Concerning the above PLAIN ABDOMINAL X-RAY (Figure #)

Responses:

- | | |
|----|---|
| A: | the patient probably has frequency of micturition. |
| B: | the lesion could be associated with menorrhagia. |
| C: | gallstone ileus is a likely diagnosis. |
| D: | the finding is more likely in a patient who has lived in India or Southeast Asia. |
| E: | pregnancy is well advanced |

Slide 7



I-0006 Bank No: 2022 Type: A

Stem: A 67-year-old woman recently noticed a non-painful lump in the right breast. The above photograph (Figure #) shows the appearance of the breast on inspection. The MOST LIKELY diagnosis is

Responses:

- A: subacute mastitis with early abscess formation.
- B: advanced adenocarcinoma of the breast.
- C: early intraduct carcinoma with obstruction of ductal ampullae.
- D: severe fibrocystic disease of the breast (fibroadenosis with multiple cysts).
- E: extensive fat necrosis of the breast.

Slide 8

MCQ CANDIDATES RANKED 1 – 10 [Merit Order]

By Country of Training, Percentage Overall Score Correct and Age at Time of Examination

Ranking	2001 A		2001 B		2002 A		2002 B		2003 A	
1	Sri Lanka		Iraq		Egypt		India		India	
	83%	36	88%	25	84%	45	91%	24	91%	28
2	India		China		Iraq		India		India	
	81%	28	87%	28	83%	41	90%	26	86%	32
3	Bangladesh		Bangladesh		Iraq		India		Bangladesh	
	81%	45	86%	33	83%	41	90%	25	86%	42
4	Nepal		Iraq		Sri Lanka		Sri Lanka		Yugoslavia	
	81%	27	86%	36	83%	31	89%	36	85%	41
5	Iran		Sri Lanka		Iraq		Bangladesh		Bangladesh	
	80%	39	86%	37	82%	32	88%	35	84%	48
6	Myanmar		Iraq		UK		Iran		India	
	80%	34	86%	31	81%	31	88%	35	84%	25
7	Myanmar		Bangladesh		India		Poland		India	
	79%	35	86%	35	81%	30	88%	35	84%	31
8	Sri Lanka		Bangladesh		Bangladesh		Egypt		India	
	79%	48	85%	34	80%	37	87%	34	83%	34
9	Bangladesh		South Korea		UK		Egypt		India	
	79%	41	84%	37	80%	28	87%	40	83%	30
10	Bangladesh		Iraq		China		Bangladesh		USSR	
	79%	36	84%	33	80%	33	87%	32	83%	38

Country of training Overall percentage correct in AMC MCQ examination Age in years at time of sitting AMC MCQ examination

Slide 9

Who Are These OTDs?

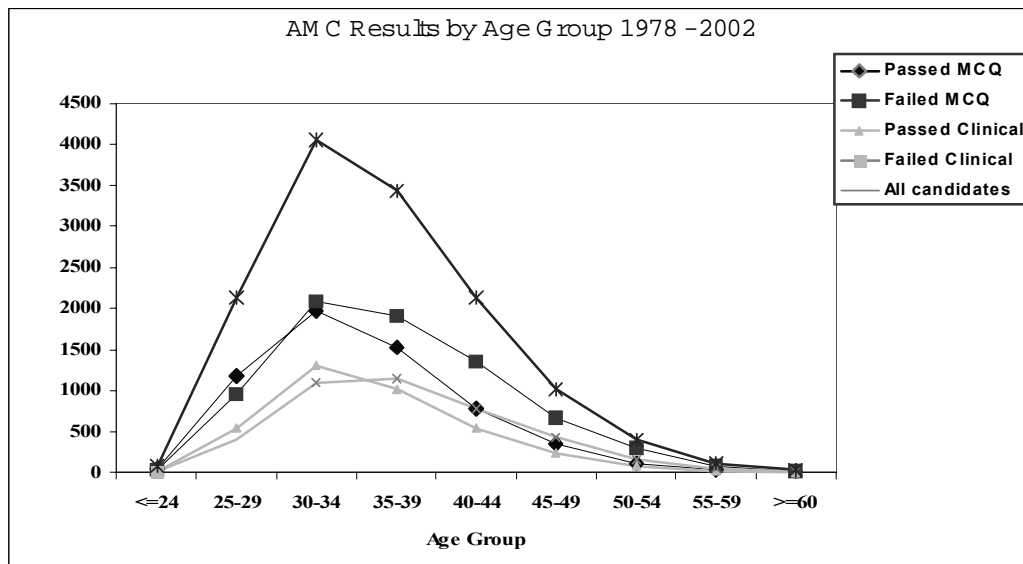
- ▼ **Pre-1978 each State had own system for recognition of OTDs**
- ▼ **Between 1978 and 2002 - 7431 OTDs presented for the national examinations**
- ▼ **5734 - 77.17% of the total - passed the MCQ**
- ▼ **4459 went on to attempt the clinical exam – 3859 – 86.52% of those who attempted clinical exam– passed and qualified for registration in Australia**
- ▼ **The candidates represent 111 countries of training**
- ▼ **The age profile of candidates ranges from 24 years to 65+ years with a mean of 30 – 34 years.**

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Slide 10

Country of Training	Total Number Cands.	% Pass MCQ	% Pass Clinical	Total Number Pass AMC Overall	% Pass AMC Overall
BANGLADESH	305	88.52	77.78	112	36.72
CHINA [PRC]	330	75.45	87.08	155	46.97
EGYPT	604	79.30	91.15	381	56.47
HONG KONG	236	88.14	80.50	128	54.24
INDIA	1082	77.26	87.34	600	55.45
IRAQ	339	91.15	90.10	173	51.03
PAKISTAN	208	73.08	83.17	84	40.38
PHILIPPINES	303	54.79	70.06	108	35.64
SOUTH AFRICA	374	86.36	92.67	253	67.65
SRI LANKA	511	86.50	86.31	309	60.47
U.K.	440	94.55	94.44	289	65.68
Total AMC [All Cands.]	7431	77.17	86.52	3859	51.92

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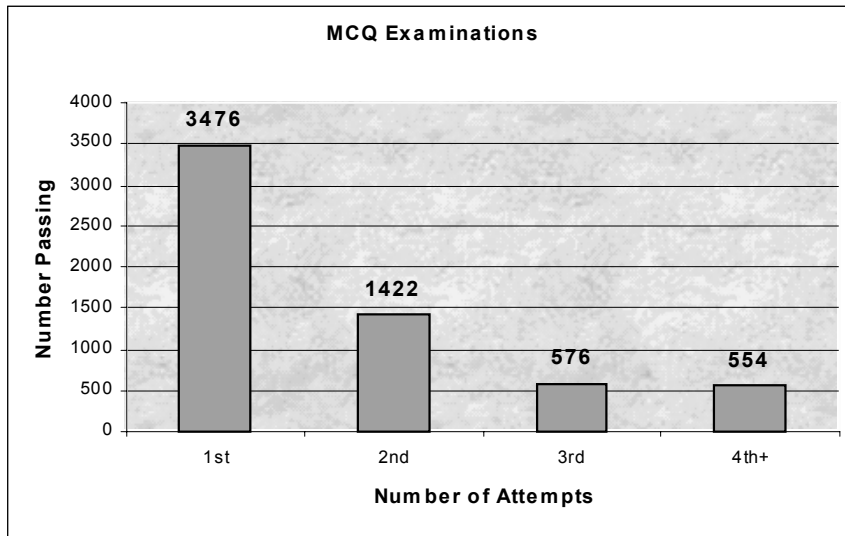
Slide 12

Performance By Topics / Systems in MCQ Examinations 2001A – 2003A

		MCQ Examination Series				
		2001 A	2001 B	2002 A	2002 B	2003 A
STRONGEST AREAS	↑	Dermatology	Major Psychiatric Disorders	Nutrition / Metabolism	Developmental Abnormalities	Major Psychiatric Disorders
		Reproductive System	Clinical Oncology	Renal System	Mental State / Behavioural Problems	Head & Neck / ENT
		Musculoskeletal System	Circulatory System	Musculoskeletal System	Reproductive System	Respiratory System
WEAKEST AREAS	↓	Developmental Abnormalities	Gastrointestinal System	Mental State / Behavioural Problems	Circulatory System	Musculoskeletal System
		Clinical Oncology	Clinical Immunology	Clinical Oncology	Respiratory System	Renal System
		Anaesthesia / Critical Care	Reproductive System	Developmental Abnormalities	Nutrition / Metabolism	Breast / Endocrine System

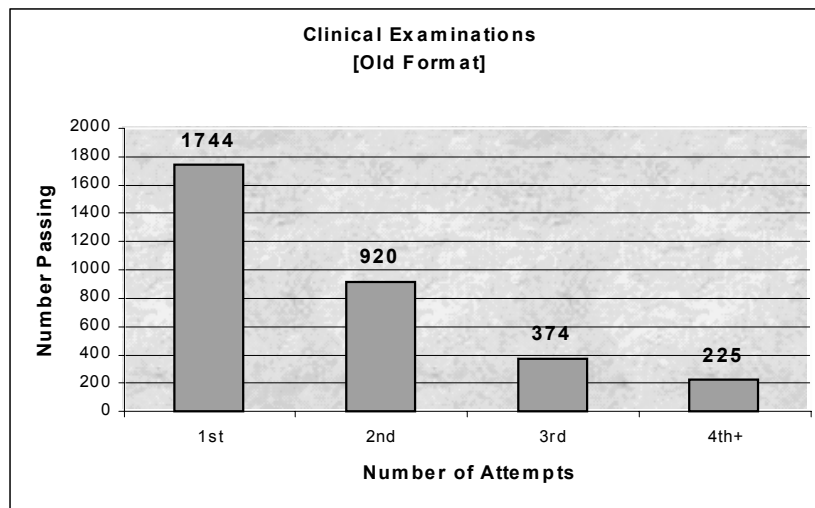
Slide 13

Pass Rates by Number of Attempts



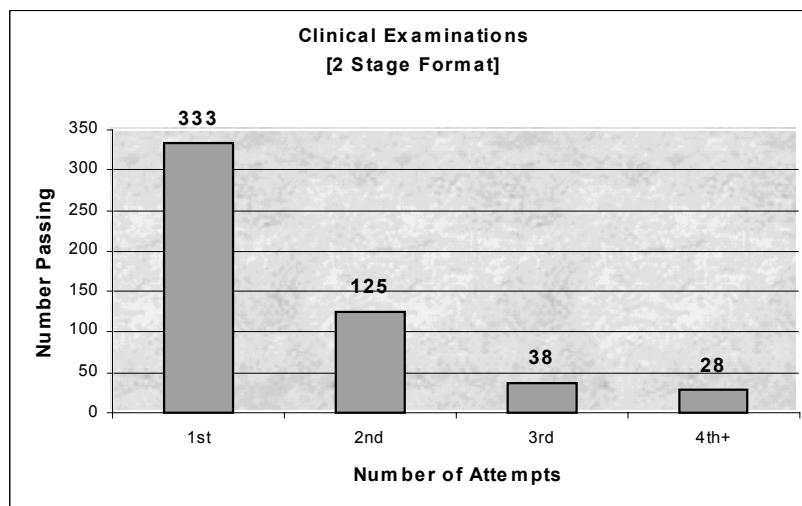
Slide 14

Pass Rates by Number of Attempts



Slide 15

Pass Rates by Number of Attempts



Slide 16

AMC Clinical Examinations

▼ Major changes in AMC clinical examinations over last decade

▼ Pre-1977 clinical exam modelled on final MBBS exams:

- Medicine Short cases / Viva
- Surgery Short cases / Viva
- O & G Long case and viva

▼ 1997 – 2001:

- Medicine Short cases
- Surgery Short Cases
- Medicine & Surgery Consulting Skills
- O & G/Paediatrics Consulting Skills

▼ 2001 – 2003: Two –stage format

- Stage 1: Medicine & Surgery Consulting Skills [74.77%]
O & G Consulting Skills [68.6%]
Paediatrics Consulting Skills [74.7%]
- Stage 2: 12 Station Medicine & Surgery OSCE [94.6%]

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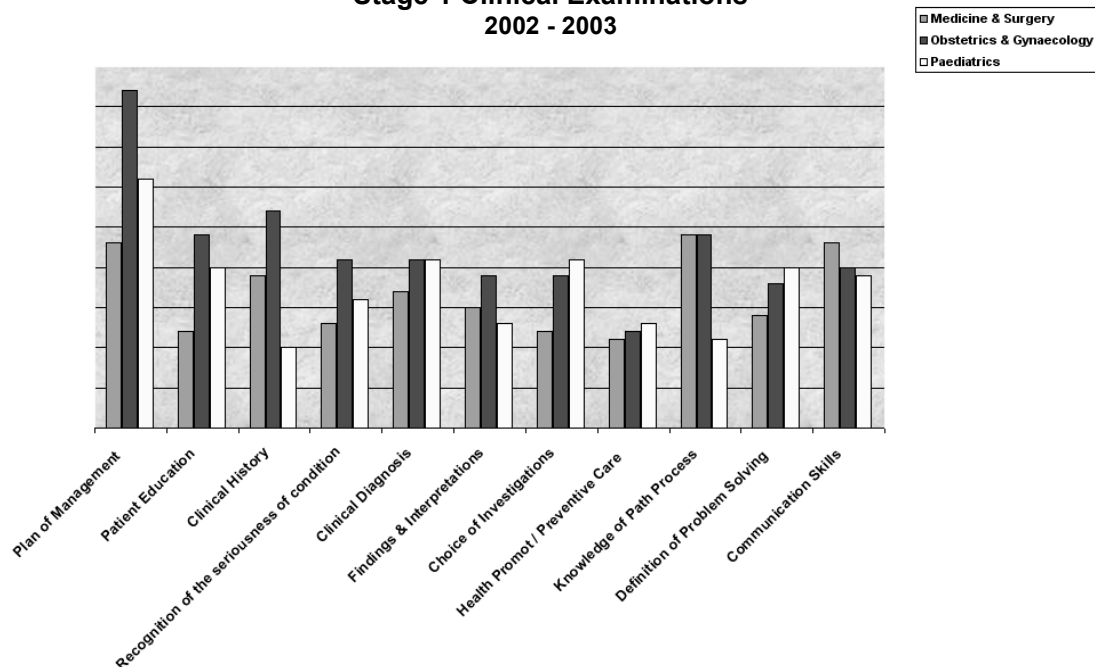
Slide 17



Unsatisfactory Performance Categories

Stage 1 Clinical Examinations

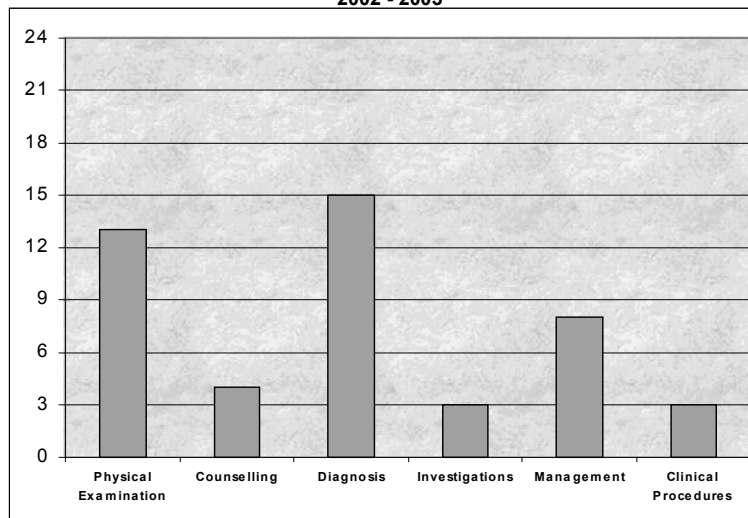
2002 - 2003



Slide 18



Unsatisfactory Performance Categories Stage 2 Clinical Examinations 2002 - 2003



Slide 19

OTD Candidate Profile

▼ **1983 Review (Fry) identified 4 categories of OTDs:**

- **I. COT with similar medical training and practice background – high pass rate**
- **II. COT moderately different – high ability – high pass rate**
- **III. COT different practice background – need short reorientation to pass**
- **IV. COT significantly different practice background – need substantial re-training and reorientation of skills to enter medical workforce in Australia**
 - [Recognition of Overseas Qualifications in Australia (Fry Committee) 1983]

▼ **Subsequent studies – more complete data – refined the categories**

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AMC candidates can be clustered into five broad groups, based on their success at the clinical exam (Table 8.1).

Table 8.1: Groups of AMC clinical examination candidates by needs

Groups / clusters	Proportion of all AMC clinical candidates	Characteristics
1. Minimal assistance Pass clinical examination at first attempt without undertaking a bridging course	37%	<ul style="list-style-type: none"> • 2.7 times more likely to be trained in countries with similar training system (40% of group) • 2.3 times more likely to have gained an exemption from English language test (48%) • 1.6 times more likely to be under 35 years (55%) • 1.3 times more likely to have MCQ scores >65 (43%)
2. Skills refresh and orientation Pass clinical examination at first attempt after undertaking a bridging course	21%	<ul style="list-style-type: none"> • 3.3 times more likely to be trained in countries with dissimilar training system (93% of group) • 2.1 times more likely not to have gained an exemption from English language test (84%) • All candidates in this group have undertaken a bridging course
3. Significant skills refresh and orientation or gap remediation Pass clinical examination at second attempt	20%	Similar characteristics to group 2 including MCQ score, except only one-third (32%) have undertaken a bridging course - indicating they are either unaware or unsuccessful at gaining places in a bridging course
4. Major assistance Pass clinical examination at third or fourth attempt	10%	<ul style="list-style-type: none"> • 8 times more likely to be trained in countries with dissimilar training system (97% of group) • 2.1 times more likely not to have gained an exemption from English language test (88%) • 2.7 times more likely to be aged 35 years and over • Over one-third (36%) have undertaken a bridging course
5. Re-training Yet to pass clinical examination after four or more attempts	12%	<ul style="list-style-type: none"> • 12 times more likely to be trained in countries with dissimilar training system (98% of group) • 6 times more likely not to have gained an exemption from English language test (94%) • All candidates in the group 35 years and over • Over half (53%) have undertaken a bridging course

Research Study on Bridging Courses
 For Overseas Trained Doctors
 ARTD Management and Research Consultants
 September 1993

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What works? What does not work?

▼ A. PROVISION OF INFORMATION TO OTDs

- **Most significant change last 15 years quality and quantity of information available to OTDs**
- **Pre-1989 only minimal information available**
 - no details on content
 - no guidance on exam preparation
 - minimal feedback on performance
- **Wide range of information now available from a variety of sources including:**
 - Exam specifications booklets
 - AMC exam publications
 - Clinical examination videos
 - AMC website
- **OTDs “strategic learners” – Source and Content**

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What works? What does not work?

▼ A. Provision of Information to OTDs – What needs to be done?

- **Supplement existing information with face to face briefings**
- **NSW Department of Health initiatives**

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What works? What does not work?

▼ B. Counselling and Feedback

- **Counselling failed candidates least successful initiative**
- **Factors:**
 - Age [57% pass under 35 years]
 - Gender [52% female – 41% male]
 - Number attempts [80+% in 2 attempts]
 - Lack of remedial opportunities
 - Current clinical experience
 - Insight *

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What works? What does not work?

▼ B. Counselling and Feedback

- Counselling failed candidates least successful initiative
- Factors:
 - Age [57% pass under 35 years]
 - Gender [52% female – 41% male]
 - Number attempts [80+% in 2 attempts]
 - Lack of remedial opportunities
 - Current clinical experience
 - Insight *

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What works? What does not work?

▼ C. Bridging Courses

- Success of bridging courses a “given”
- Successive Governments intermittent funding of programs – variable results
- AMC limited data highlights problems
- Independent study of comprehensive data finds:

At the broadest level, the candidate pass rate of clinical bridging course participants is not significantly higher than the pass rates of candidates who have not completed a bridging course.

– [ARTD 1999 Study on Bridging Courses]

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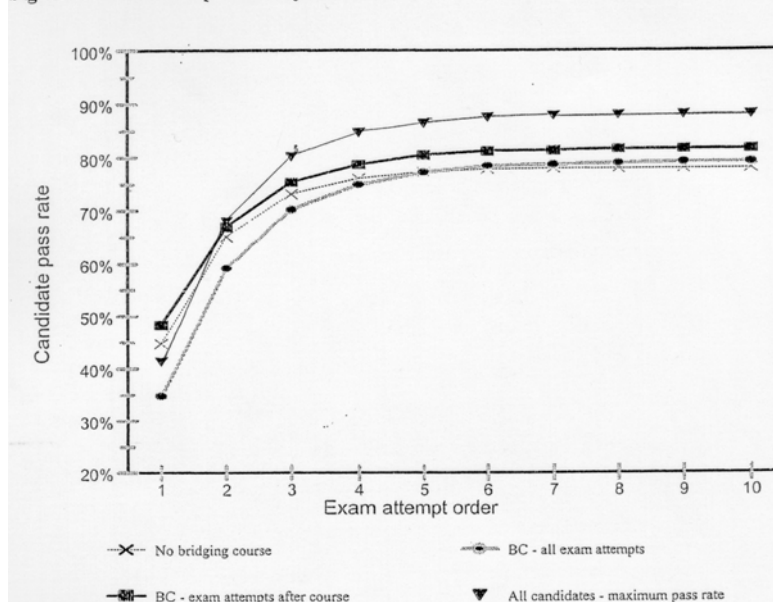
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IMPACT OF BRIDGING COURSES ON CLINICAL EXAMINATION PERFORMANCE

	Pass Rates Bridging Course Participants	Pass Rates AMC Candidates Overall
EXAMPLE 1: Pre-2 Stage Format – Examination place not linked to completion of bridging course		
Bridging Course participants examined up to 12 months after completion of course	37.5% [N=15]	36%
EXAMPLE 2: Pre-2 Stage Format – Examination place linked to completion of bridging course		
1998 Course	71% [N=15]	35%
1999 Course	62.5% [N=15]	41%
EXAMPLE 3: Pre-2 Stage Format – Examination place linked to completion of bridging course		
May 2001 Course	56% [N=16]	58%
EXAMPLE 4: 2 Stage Format – Examination place linked to completion of bridging course		
2003 Course	50% [N=14]	51%

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Figure 7.1: Candidate pass rate by exam order



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What works? What does not work?

C. Bridging Courses

ARTD study identified COT influence:

Bridging course participation	Pass Rates	
	Similar COT	Different COT
All candidates	69%	40%
Bridging course	85%	47%
Non bridging course	68%	36%

ARTD Conclusion:

Bridging course participants have higher pass rates than non-bridging course participants, particularly for candidates trained in countries with dissimilar training systems to Australia.

However, the impact of bridging courses relates to participants' first attempt after completing the course, with much smaller differences after subsequent attempts. This implies that the contribution of bridging courses is to accelerate progress in the AMC examination process rather than to determine whether candidates will eventually pass or fail.

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What works? What does not work?

▼ C. Bridging Courses What needs to be done?

- Recognise the diversity of OTDS and tailor assessment systems and re-training programs to reflect this diversity
- Recognise the distinction between:
 - Orientation
 - Bridging
 - Retraining
- Where possible – integrate assessment for registration with bridging / retraining
- Think outside the square

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