COMMISSION OF INQUIRY NO. 1 OF 2005
MEDICAL BOARD OF QUEENSLAND

This is the annexure marked "**JPO-18"** mentioned and referred to in the Statement of **JAMES PATRICK O'DEMPSEY** dated this 17th day of May 2005.

AUSTRALIAN MEDICAL COUNCIL
INCORPORATED
ABN 19 814 243 263

DEVELOPMENT OF ASSESSMENT PROCESSES FOR OVERSEAS TRAINED DOCTORS – INCLUDING AREA OF NEED SPECIALISTS

Background

1. Prior to 1978, each State and Territory Medical (Practitioners) Act included lists of medical qualifications that were recognised for the purposes of registration. By 1978 the recognised qualifications listed were the (then) 10 Medical Schools in Australia, the 2 New Zealand Medical Schools and the UK Medical Schools that had been accredited by the General Medical Council of the UK. (Tasmania also recognised graduates of South African medical Schools).

2. The assessment of overseas medical qualifications for registration in Australia varied between States. Attempts were made to develop objective and structured processes for assessment and, in 1972, Victoria established an independent examination [the Foreign Practitioners Qualifications Certificate (FPQC)] based on the final qualifying examination of the University of Melbourne.

National Examination for OTDs Agreed by Medical Boards

3. In 1978, the State and Territory Medical Boards agreed to adopt the FPQC examination as a national screening examination for overseas trained doctors (OTDs). The Australian Medical Examining Council was established under the auspices of the (Commonwealth) Committee on Overseas Professional Qualifications) to administer the national examination. Eligibility to sit the AMEC examination was restricted to Australian citizens, permanent residents and applicants for migrant entry to Australia. The examination was not prescribed by statute.

4. In August 1984 the Australian Health Ministers' Conference, following recommendations from the Standing Committee of the Health Ministers' Conference, agreed to establish the Australian Medical Council (AMC) to accredit medical schools and courses leading to basic medical qualifications and make recommendations to State and Territory Medical Boards concerning uniform approaches to registration of medical practitioners. The Council was also given the responsibility for administering the national examinations for OTDs (AMEC examination) The Council commenced operations in January 1985 and assumed responsibility for the examination in January 1986.

Separate Pathway for Overseas Trained Specialists

5. Prior to 1990, overseas trained specialists were required to pass the AMC (non-specialist/general practitioner) examination in order to obtain general registration to practise in Australia and then seek recognition of their specialist training though the Specialist Recognition Advisory Committees (SRACs), State-based recognition bodies established under the provisions of the (Commonwealth) Health Insurance

Act to determine the recognition of individual specialists for the purposes of Medicare.

6. In 1989 the New South Wales Committee of Inquiry into Recognition of Overseas Qualifications (NSW 'Fry Report') recommended that a different pathway be provided for the assessment and registration overseas trained specialists from that for non-specialist registration.

7. In 1990, the New South Wales Medical Board approached the Specialist Medical Colleges individually for assistance with assessing overseas trained specialists. Where the specialist was assessed as equivalent or near-equivalent to Australian trained specialists in the relevant field of specialist practice, he or she was granted registration for independent practice limited to the assessed field of specialty.

Health Ministers Agree to National Standards for Assessment of OTDs

8. In March 1991, the Australian Health Ministers Conference, in anticipation of the implementation of the mutual recognition scheme, agreed to recommendations of an Australian Health Ministers Advisory Committee (AHMAC) Working Party (the Clark Committee) on a national standard for registration for independent practice. The two principal categories were:

    - General Registration (registration without conditions)

        A. Graduates of medical schools in Australia and New Zealand that had been accredited by the AMC; and
        B. Graduates of other medical schools who had passed the AMC examination

    - Registration for Specialist Practice (registration with conditions limited to the field of specialist practice)

        OTDs who had been assessed by the relevant Specialist Medical College as equivalent or near equivalent to an Australian trained specialist

9. Following the decision of the Health Ministers, legislation was amended in all but one State (South Australia) to formally prescribe the AMC examination for non-specialist registration and to withdraw the recognition of UK qualifications (and South African qualifications in the case of Tasmania). The relevant legislation was also amended to permit overseas trained specialist who had been assessed as equivalent to an Australian trained specialist to be granted "limited" registration for independent practice.

Growing Problem of Area of Need

10. Although a measure of national consistency had been achieved with the 1991 Health Ministers decision, each State and Territory retained discretionary provisions under their individual Acts, to grant registration with conditions to individual medical practitioners, who did not meet the agreed national standards for independent practice, in circumstances where it was deemed by the relevant Board to be "in the public interest". This category, which is also known as "area of need" registration,

was to increase in significance as the numbers of area of need positions increased from some 600 in 1992 to over 4000 in 2002/2003.

11. In 1992, an AMC/Committee of Presidents of Medical Colleges (CPMC) Joint Workshop on Assessment and Registration of Overseas Trained Specialists identified (inter alia) the need for consistency in assessment processes. In 1993, a national process was adopted, with the AMC becoming the first point of contact for overseas trained specialists seeking registration in Australia and taking on the role of a 'clearing house' for the Specialist Medical Colleges (which set the standards of specialist medical practice in Australia) and the Medical Boards in relation to specialist assessment and registration.

12. After 1993, the specialist assessment processes developed in sophistication, but lacked a measure of consistency between the Colleges, as each College attempted to administer the processes within the context of its own philosophy, by-laws and governing regulations.

13. The Medical Boards, had their own individual approaches in responding to Colleges' requirements relating to – for example - examinations and their timing, and top-up training - in terms of the registration of individual overseas trained specialists. Issues facing the Colleges and Boards included:

    - the fact that the process was developed as a means of recognising fully trained overseas trained specialists rather than providing an alternative training pathway
    - differing understanding of the purpose and philosophy of the specialist assessment process
    - different local conditions and requirements that emerged over time.

Moves to Improve Assessment of Overseas Trained Specialists

14. In April 1999, a Joint AMC/CPMC Workshop on Assessment and Registration of Overseas Trained Specialists determined that a standard assessment process across all Colleges would assist all stakeholders in the process and provide a more consistent outcome. The result was the introduction, in April 2000, of pro forma reporting by the Colleges on the outcomes of their initial and final assessments of overseas trained specialists and the adoption across all Colleges of a ***Template*** for the procedures for assessing overseas trained specialists.

15. The ***Template*** covers aspects such as:

    - documenting criteria for assessment and procedures for assessment
    - establishing a committee to undertake assessments
    - evidence used for assessment
    - action to be taken by a College on receipt of an application
    - interview arrangements and procedural fairness
    - further assessments
    - mediation and appeals process.

16. The adoption of the pro forma reports and the ***Template*** had the effect of streamlining communication between the Colleges, the AMC, applicants and the Medical Boards. The templates have been widely accepted – particularly by

applicants, who now receive their own copy of the results of College assessments as issued by the Colleges themselves. This documentation has also contributed to an improved procedural robustness and overall consistency of approach to specialist assessment in Australia.

17. From January 1993 to 10 May 2005, the AMC has processed a total of 2802 applications for specialist assessment through the 'standard' pathway (that is, for overseas trained specialists seeking recognition for the purpose of registration for independent specialist practice in Australia).

Proposed National Approach to Area of Need Assessment

18. In December 1995, in response to growing concerns about the numbers of OTDs that were being placed in "area of need" positions, with little or no formal assessment, the AMC was asked by the Commonwealth Department of Health to provide advice on a national approach to assessment and registration of doctors for Area of Need positions. The AMC established, a Working Party, which after consultation with key stakeholders, prepared an options paper for AHMAC, entitled ***A Structured Approach for Area of Need Registration***. The paper proposed a structured approach to Area of Need registration which matched individual practitioners to the service needs of the Area of Need positions. It addressed aspects of Area of Need registration such as:

    - definition/categorisation of Area of Need positions in terms clinical responsibility and available levels of supervision
    - open processes for assessment and registration, including matching of the individual to the requirements of the position
    - supervision issues and the ongoing monitoring of standards.

19. The AMC's report was submitted to AHMAC in May 1996 but was not adopted. The AMC was informed at the time that the lack of support was due primarily to concerns about the potential negative impact of the proposed assessment process on the medical workforce.

20. In April 1999 a Joint AMC/CPMC Workshop on Assessment and Registration of Overseas Trained Specialists (referred to above) agreed that appointments to Area of Need specialist positions should not be assessed at a lesser standard than that applied to permanently resident overseas trained specialists. Following the Workshop, debate continued surrounding workforce issues and concerns about the practical difficulties involved in using the same assessment processes for Area of Need specialists as for permanent resident specialists.

New Initiatives – "Five Year" GP Scheme

21. In 1998 new initiatives were announced by the Commonwealth Minister for Health and Aged Care for recruiting OTDs with postgraduate training and experience in general practice for positions in rural or remote areas. The new assessment process, known as the "Five Year Scheme", was formally approved by Health ministers in August 1999. Under this scheme, OTDs with appropriate GP training who were assessed as equivalent to the Fellowship of the Royal Australian College of General

Practitioners (or within 2 years of completing the FRACGP) were granted limited registration to work in designated area of need general practice positions.

22. Under the "Five Year Scheme", if the OTDs completed the FRACGP they would be granted registration for "general practice" (in effect, registration without conditions). The practitioners were required to work in the designated positions for 5 years, after which they could move to any location in Australia and would be able to retain their Medicare provider number, by-passing the 10 year moratorium on access to Medicare provider numbers.

Alternative Approach to Area of Need Specialists

23. As the Five Year Scheme was being developed, the New South Wales Department of Health and the Medical Board of New South Wales approached a number of Specialist Medical Colleges to assist in the recruitment process by assessing overseas trained specialists for Area of Need positions – not to the same standard (or 'equivalence') as Australian trained specialists, but against the requirements of particular positions.

24. In August 1999, the newly established CPMC/AMC Joint Standing Committee on Overseas Trained Specialists considered a draft proposal for a fast-track assessment process for Area of Need positions. The proposal was circulated for consideration by the Specialist Medical Colleges.

25. In September 1999, the Royal Australasian College of Physicians (RACP) developed a proposal for an alternative model for the evaluation of overseas trained specialists for Area of Need positions based on a defined position description, matching qualifications and experience of the applicant to the position, and ongoing assessment and monitoring. The model was very similar to the AMC model developed for AHMAC in 1996. The CPMC's Working Group on Area of Need Assessment invited the AMC to review its model in line with the RACP proposals.

2000 Area of Need Specialist Forum

26. Against a background of continuing concern by governments for the implementation of solutions to the shortage of specialists in Areas of Need, a CPMC/AMC Forum was held on 1 December 2000 to bring together a wide range of stakeholders to develop a flexible and responsive model for fast-track assessment of overseas trained doctors selected to fill Area of Need positions. The model was to be an adjunct to the AMC/Specialist Medical College pathway for assessment of overseas trained specialists that was implemented in 1993.

27. The model considered at the Forum focused on four discrete elements:

    - a detailed position description for each Area of Need position, where possible developed with input from the relevant Specialist Medical College
    - initial assessment by the relevant College of the preferred applicant, against the position description and selection criteria
    - registration by the relevant Medical Board to reflect the requirements of both the position and the experience of the applicant
    - provision for ongoing assessment and monitoring by the relevant College.

28. On the basis of the broad agreement reached at the Forum concerning a model for an assessment process for Area of Need practitioners, the CPMC/AMC Joint Standing Committee on Overseas Trained Specialists undertook extensive stakeholder consultations on a new national assessment process for Area of Need specialists.

Agreed National Process for Area of Need Specialists

29. In April 2001, as part of the consultative process, all State and Territory Health authorities were asked by the Commonwealth Department of Health and Aged Care to advise on implementation of the proposed Area of Need specialist assessment process, including possible timelines, and on specific material for inclusion in a User's Guide that would assist all parties to implement the new process. All the responses received were considered in the drafting of the ***User's Guide - Assessment Process for Area of Need Practitioners*** [later amended to ***Area of Need Specialists***, to distinguish the new process from the arrangements already in place for recruitment of rural or remote area general practitioners].

30. In September 2001, a working draft of the ***User's Guide*** was circulated by the AMC to key stakeholders for feedback in relation to the process outlined in the document. Final editing of the ***User's Guide*** was completed in December 2001, and printed copies were circulated by the Commonwealth Department of Health and Ageing for the process to be implemented from 1 June 2002. The AMC/CPMC Joint Standing Committee on Overseas Trained Specialists has responsibility for monitoring the Area of Need processes for assessment of overseas trained specialists (as well as assessments through the 'standard' pathway).

31. The Area of Need process is broadly similar to the procedures for specialist recognition for the purpose of conditional registration for independent/ unsupervised practice (the 'standard' pathway). However, the major procedural differences are designed to enable Colleges to match the specific skills of the individual applicant to the specific requirements of the Area of Need position and to complete their assessments and make recommendations to the relevant Medical Boards within six to eight weeks of receiving a satisfactory application. This arrangement reflects the particular urgency that is usually associated with Area of Need recruitment and appointments.

32. A flow-chart outlining the steps in the assessment process is attached, and is reproduced from the ***User's Guide*** [pages ii and iii]. Copies of the ***User's Guide*** can be downloaded from the AMC's website at www.amc.org.au/aondocs.asp

33. The AMC's primary role is to participate in the process on behalf of the Colleges and Medical Boards by determining, on the basis of jointly agreed criteria, the eligibility of applicants to proceed to assessment.

34. Medical Boards have sole responsibility for granting **conditional registration** to overseas trained specialists who have been selected as suitable for consideration for employment in designated Area of Need positions. The conditions attached to such registration usually include restrictions such as the location, duration, nature and extent of practice, and arrangements for supervision and ongoing assessment,

reflecting the particular requirements of the practitioner and the Area of Need position, locality and population.

35. From 1 June 2002 to 10 May 2005, the AMC has processed 474 applications through the Area of Need assessment pathway.

36. Despite the national agreement on the Area of Need assessment pathway, there appears to be a significant number of overseas trained specialists, particularly in Area of need positions, who have been registered but have never lodged an assessment application with the AMC. *[Commonwealth recruitment data from the "strengthening Medicare" initiative (see para.38 below) indicates that 25% of doctors recruited under the scheme were specialists. If this is applied to the total number of temporary resident doctors (TRDs) who were granted visas in 2004, it would suggest that there were some 796 overseas trained specialists who entered Australia as TRDs in 2004. The total number of Area of Need specialist applications processed in 2004 by the AMC was 157.]*

37. On 1 May 2003, the AMC/CPMC Joint Standing Committee on Overseas Trained Specialists sent more than 175 Circulars to: individual applicants, employers, recruitment agencies, Commonwealth, State and Territory Health Departments, State and Territory Medical Boards, the Specialist Medical Colleges, the Australian Medical Association, Health Insurance Commission; and Department of Immigration and Multicultural and Indigenous Affairs inviting them to participate in the review of the process. Only 27 responses were received. While there was overall support for the new process, some responses showed that there were major concerns in areas such as costs, the length and the complexity of the process.

Commonwealth Medicare / Medical Workforce Initiatives

38. On 18 November 2003, the Commonwealth Government announced a package of measures (Medicare Plus – now *Strengthening Medicare*), including reforms to increase the medical workforce by 'reducing red tape' and streamlining aspects of the assessment process for overseas trained doctors. One of the deliverables under the *Strengthening Medicare* package was the improved alignment of the State and Territory "area of need" determinations (for registration purposes) and the Australian Government's "district of workforce shortage" determinations (for Medicare purposes).

39. The AMC was asked by the Commonwealth to streamline its processes for the assessment of OTDs for non-specialist (general) registration. The major initiatives targeted for action by the AMC were:

    - Streamlining of the AMC clinical examination with increased availability for assessment. [This was implemented in 204 with the total number of clinical examination places increased from 450 to 900 per year. The out put of the AMC examination has increased from 250 to approximately 500 per year.]
    - Implementation of a computer-administered MCQ examination format and increased frequency of assessment. [This was implemented in March 2005 with the number of MCQ examinations increased from 2 to 5 per year.]
    - Development of a computer-administered MCQ screening examination that could be available outside Australia at more frequent intervals than the then current

MCQ examination. [This is being developed as a joint project with the Medical Council of Canada and is expected to be available from July 2006 with monthly administrations when fully developed.]

40. As part of the development of the Off-shore screening examination, the AMC has initiated discussions with the Education Commission for Foreign Medical Graduates of the Untied States, to undertake primary source verification of medical qualifications. This process currently applies to all OTDs who lodge application to sit screening examinations conducted by the Medical Council of Canada and the United States licensing examinations. It is expected that primary source verifications for all AMC candidates will be implemented by the end of 2005.

41. A Joint Working Group on Overseas Trained Specialists (on which the AMC is represented) was convened by the Australian Department of Health and Ageing to progress the development of suitable proposals to 'reduce red tape'. The Department also convened a Stakeholder Workshop on 12 March 2004 on the Assessment of Overseas Trained Specialists for Employment in Area of Need Positions. The AMC, as a key stakeholder, continues to be represented on a number of committees convened by the Department that are working towards the implementation of the reforms and associated measures.

42. In relation to Area of Need assessment, the Stakeholder Workshop supported a multiple approach based on the extent of information and supporting evidence on the qualifications and relevant experience of the individual and specific requirements of the Area of Need position. It was proposed that there be three categories:

    Category 1: Overseas trained specialists who fall within an agreed group of recognised/accredited qualifications/training, who would not require formal assessment through the Specialist College pathway.

    Category 2: Overseas trained specialists, who did not fall within the first category, but had a strong track record and verifiable qualifications and experience. Individuals in this category would be assessed as part of the original selection/recruitment process, which would include input from the relevant Specialist College, but would not require formal assessment through the Specialist College pathway.

    Category 3: Overseas trained specialists whose fitness-for-task for the specific Area of Need position is not clear and who will require formal assessment through the Specialist College pathway.

43. The Department of Health and Ageing continues to work with the Specialist Medical Colleges and other stakeholders to develop the Category 1 group of qualifications proposed by the Workshop.

44. As part of these activities, criteria have been developed for identifying overseas qualifications suitable for acceptance without College assessment (Category 1). The criteria – which will identify the minimum standard as a standard of quality that would be acceptable to the Australian community – require three aspects of qualifications to be assessed, namely:

- the training program (that is, goals, entry requirements, format and content/structure of training, training environment, accreditation)
- assessment and/or examination (through a systematic program of formative and summative assessments appropriate to the specialty)
- professional development program (qualification supported by access to a professional development program and/or peer review and audit programs).

45. Further work is proceeding in relation to the principles and process for assessing recency of practice for Category 1 applicants.

ACCC Investigation of Royal Australasian College of Surgeons

46. In 2000 the Australian Consumer and Competition Commission (ACCC) initiated an inquiry into the activities of the Royal Australasian College of Surgeons (RACS), including the assessment of overseas trained surgeons. The College applied for authorization under the provisions of the Trade Practices Act, and as `a condition of authorization granted in 2003 was required to conduct an independent review of its assessment procedures. The final Report of the Review of the Assessment of Overseas Trained Surgeons was completed on 15 April 2005 and has now been circulated. The Report recommends (among other things) that:

    - the AMC provide external oversight of the Royal Australasian College of Surgeons (RACS) by monitoring the effectiveness and performance of the College's overseas trained surgeons assessment process

    - there should be consultative development (involving the AMC, College and jurisdictions) of appropriate structural, governance and funding arrangements, which should include consideration of arrangements for a review of the implementation, operation and effectiveness of the proposed AMC body once that body has been established for 12 months.

47. The assessment model proposed by the Review Committee will, if implemented, continue to involve the AMC in a 'clearing house' role. However, the model merges the currently separate 'standard' (AMC / Specialist College) pathway and the Area of Need specialist assessment pathways into one. It also provides for 'streaming' of applicants into three categories: those with recognised surgical qualifications; no currently recognised surgical qualification; and self-initiated applicants.

48. The AMC will now consult with the RACS and jurisdictions to clarify issues surrounding the proposed monitoring of the College and the associated resource requirements. The RACS Review has obvious implications for all other Australian or Australasian Specialist Medical Colleges: these will be considered in detail over the coming months.

2005 National Forum on Assessment of TRDs for General Practice Positions

49. On 20 April 2005 the Commonwealth Department of Health and Ageing hosted a national forum on the assessment of temporary resident doctors for general practice in Australia. The Forum agreed to adopt the key elements of a discussion paper that had been prepared by the Registrars Sub-Group of the AMC Joint Medical Boards

Advisory Committee (JMBAC) as a framework for the development of a national strategy for TRD assessment. The key elements were:

a) Verification of Qualifications – primary source verification [national basis]
b) International Screening Examination (AMC/MCC model) [national basis]
c) English language proficiency [agreed national standard]
d) Assessment [local] of TRD for specific position (may include one or more of the following):
    - Review according to National Reference Panel categories
    - Assess fitness for defined area of need position
    - Clinical interview
    - Clinical exam
e) Consideration by Medical Board – conditions set [local basis]
f) Post-registration supervision / monitoring / reports [local basis]
g) Participation in MOPS / CPD [national standard]
h) Completion of FRACGP / AMC requirements for full registration within defined period [national standard]

The formal proceedings of the Forum are currently being prepared.

17 May 2005

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Assessment Process for Area of Need Specialists

Step 1

Employer identifies position requiring to be filled and contacts relevant Specialist Medical College for assistance with preparing detailed position description and key selection criteria in terms of clinical responsibility and qualifications or experience required.

NOTE: It may be possible to find an alternative solution to declaration of position as Area of Need.

College will advise on match of skills and expertise required for specific position. Employer to specify remuneration package, indicating whether applicant will be providing services that will need to attract Medicare rebates: if access to Medicare is required, contact the Department of Health and Ageing.

Step 2

Employer contacts State Health authority to have position declared as Area of Need. If position approved as such, the following process can proceed.

Step 3

Employer matches applicants for Area of Need positions against position description and selection criteria, and selects suitable applicant. Applicant and employer complete relevant documentation, *including visa application, where necessary.*

Step 4

Employer refers application to Specialist Medical College for assessment

College conducts initial assessment, based on position description and application.

SATISFACTORY
College usually conducts interview to clarifyand confirm applicant's suitability for position.

UNSATISFACTORY
College notifies employer, who takes appropriate action to: redefine position description; resubmit further information; or propose an alternative applicant. College notifies AMC in parallel.

and

Employer refers application to AMC to verify documentation

SATISFACTORY
AMC notifies Medical Board and College.

UNSATISFACTORY
AMC returns documents. Employer liaises with applicant to ensure compliance with requirements.

Step 5

College recommendation to Medical Board (within 8 weeks of receipt by College of satisfactory documentation)

College recommends applicant for consideration by Medical Board for appropriate category of Area of Need registration **and** defines any limitations on nature and extent of practice involved. College notifies employer and AMC in parallel with Medical Board.

Step 6

Medical Board consideration

Applicant applies and is considered for Area of Need registration in accordance with provisions of State or Territory Medical Practitioners Act. Medical Board notifies employer, College, Health Insurance Commission (SRACs) and AMC of decision.

Registration will be linked to further assessment and monitoring by the relevant College.

Does applicant need a Medicare Provider Number?

Step 7

NO No further action by Commonwealth

YES

1. Applicant applies for exemption from Provider Number restrictions, which gives access to Medical Benefits Schedule + consultation items at A2 level.
2. If applicant requires access to A3 items, he or she must apply to SRACs/OSACs.

Step 8

Ongoing action

College undertakes ongoing assessment after a defined period (initially 3 months and follow-up, as required, and after 12 months) – findings reported to employer and relevant Medical Board.

If any major deficiencies are notified by a College, the relevant Medical Board may alter conditions of registration (if deficiencies are not significant) or withdraw the registration if deficiencies are considered significant or constitute a danger to the community.

An applicant holding Area of Need registration may apply to proceed through AMC/Specialist Medical College pathway for overseas trained specialists, in which case the College may use alternative assessment methods.

Appeals: the mechanisms already available under Specialist Medical College and Medical Board arrangements can be utilised to resolve appeals by applicants for Area of Need positions.

The Joint CPMC/AMC Standing Committee on Overseas Trained Specialists will monitor and review the operation of the assessment process over the next 12 months. A further National Forum should be convened 12 months after the introduction of the assessment process, to review progress and propose any further improvements that may be necessary.

COMMISSION OF INQUIRY NO. 1 OF 2005
MEDICAL BOARD OF QUEENSLAND

This is the annexure marked "**JPO-19"** mentioned and referred to in the Statement of **JAMES PATRICK O'DEMPSEY** dated this 17th day of May 2005.

ATTACHMENT A

AUSTRALIAN MEDICAL COUNCIL
INCORPORATED
ABN 19 814 243 263

REPORT TO THE AUSTRALIAN HEALTH MINISTERS ADVISORY COUNCIL ON A STRUCTURED SYSTEM FOR AREA OF NEED REGISTRATION

INTRODUCTION

This report has been prepared by the Australian Medical Council (AMC), in consultation with State and territory Medical Boards, in response to a request for advice from Health Ministers. The intention is to address the following aspects of "area of need" registration:

- Definition/categorisation of area of need positions in registration terms
- Open processes for assessment and registration by Medical Boards
- Supervision issues and the monitoring of standards.

The report attempts to demonstrate that a system of classification, or categorisation of area of need positions could be derived which would assist Boards to assess and register doctors from untested backgrounds. It is hoped that this report could form the basis of a national approach to "area of need" registration and would lead to a consistent, safe, responsible, and non-discriminatory approach, to the registration of overseas trained doctors who do not satisfy the requirements for general registration (without conditions).

The system proposed is based solely on issues relevant to Medical Boards and the AMC Committees of Examination, Accreditation, and Uniformity. That is, it solely addresses issues related to standards for example, patient safety, the maintenance of Australian qualities of medical practice, and the confidence of the Australian public in their expectation of Australian doctors. The AMC acknowledges that in other settings the system is relevant to political and economic issues such as, manpower concerns and the cost of the health system - however, these are not part of its brief.

DEFINITION OF MAJOR CONCERNS

The community has an expectation of having access to health services which places demands on Governments and employers to meet medical workforce requirements. Medical Boards have the responsibility under legislation for standards issues and the need to ensure that medical practitioners meet the legal requirements for registration and maintain appropriate standards of medical practice.

A secondary, but no less important issue, is the perception that certain Medical Boards may be acting in a discriminatory manner in granting registration to Temporary Resident Doctors (TRDs), who have not satisfied any formal examination requirements in Australia, while bypassing Permanent Resident Overseas Trained Doctors (ROTDs) who have passed the AMC MCQ examination from consideration for "area of need" registration. Such Medical Boards may be vulnerable to accusations of adopting a "closed shop" attitude.

AREAS OF AGREEMENT OR CONSENSUS

There is a consensus of views amongst Medical Boards on a number of issues, including:

- The need for a consistent approach by all Medical Boards to "area of need" registration in view of the implications of mutual recognition.

- Since practitioners registered in area of need positions have not been "tested" and have not met the agreed national standards for general registration, the issue of supervision becomes critical for Boards to fulfil their obligations under legislation to protect the public.

- The need for qualifications and experience to match the service requirements and clinical responsibility of the position.

- If "area of need" registration is "open-ended" and accumulates over time, there is an expectation of continuing registration and removal of conditions on medical practice. "Area of need" registration should not be seen as a means of circumventing the formal assessment processes or as an alternative pathway to general registration.

- To avoid the practice of periods of registration being accumulated in different states there should be a maximum limit on the total period of time that a practitioner can be granted conditional registration in area of need positions. The maximum period should be cumulative across all States.

- The registration of a medical practitioner in an area of need position should be determined on standards issues rather than on workforce considerations.

- Overseas trained doctors who are granted conditional registration in area of need positions should not be exempted from the provisions of the AMC examination for the purposes of registration without conditions.

- The issue of existing long-term "area of need" registration cases was a local matter and should be reviewed and dealt with by each Medical Board.

The AMC also notes that the Australian Medical Workforce Advisory Committee (AMWAC) Benchmark study has shown that maldistribution problems and health service delivery issues in Australia are such, that there will be a reliance on TRDs for at least 5 years and in some States the demand for TRDs will remain high. It is almost certain that ROTDs (AMC candidates) will not be able to meet all the demands for "area of need" registration. If the access to TRDs is denied there will be major health service problems in a number of states.

POSSIBLE MODEL FOR A STRUCTURED APPROACH TO AREA OF NEED REGISTRATION

GENERAL PRINCIPLES

If Medical Boards can agree on a standards framework for "area of need" registration, the same framework can assist employers and service providers to define their positions and to match individual practitioners to the service needs of the positions. Overseas trained doctors, whether resident in Australia or recruited from overseas, could be considered against this standards framework in determining their eligibility for "area of need" registration.

It is important to note, that "area of need" registration is intended to meet identified medical service needs that can not be satisfied by fully qualified medical practitioners. Therefore, "area of need" registration is generally intended as an interim or limited term provision. It should not be seen as an alternative pathway to continuing medical registration.

STANDARDS FRAMEWORK

The system proposed below attempts:

1) To include guidelines which would match job characteristics to the perceived qualifications of overseas trained doctors.

2) These guidelines are both descriptive and in a fairly rough sense quantitative.

3) In all cases there is an attempt to tie the guidelines back to Australian standards.

The process of assessment for the purposes of registration involves the following components:

1) Face validity measures of a good match between the requirements of the position and the qualifications and experience of the individual ROTD or TRD.

2) Provision for pre-appointment procedures that may be adopted as part of the assessment.

3) Provision for supervision.

4) Provision for supervision and monitoring to ensure appropriate performance levels and safety are maintained.

FACTORS TAKEN INTO CONSIDERATION

The following factors were considered in arriving at a system of categorisation and guidelines for "area of need" registration:

1) The role of the Medical Board is to register appropriately qualified medical practitioners to ensure that they can provide medical services with safety to the community.

2) When an "area of need" is declared, the responsibility of the employer/service providers is to match individual medical practitioners for employment in those positions against the agreed registration criteria.

3) The area of need categories should reflect the level of clinical responsibility of the position as well as the extent, availability and quality of the supervision.

4) Under all circumstances, the principal consideration for matching a doctor with a position will be a consideration of the standards required for a safe and reliable practice in line with Australian medical graduate standards.

5) That the supervisory needs of doctors granted "area of need" registration will need to be clearly defined, because they have not been through an accredited medical school, or completed the AMC exams.

6) Under all circumstances, conditions of assessment and monitoring will need to be defined.

7) Since "area of need" registration should not be an alternative to general registration, registration in area of need positions should be time limited - generally not more than two years and cumulative nationally.

   * If ROTDs (AMC candidates who have passed the MCQ examination) are nominated by employers/service providers for "area of need" registration, continuation of the registration should be subject to evidence of appropriate progress in the assessment for general registration.

   * If TRDs are nominated for "area of need" registration, the registration should be limited to two years on a contract basis and the TRD should not be eligible to sit the AMC examination.

8) Medical practitioners in "area of need" registration who fail to demonstrate satisfactory progression in AMC clinical examinations or in supervisors' reports, should have their supervision categories reviewed or be transferred to another category of registration with conditions, if appropriate.

9) A mechanism should be established in each state to ensure that Medical Boards can be confident that placements terms and rotations are appropriate to the particular overseas trained doctors (whether ROTDs or TRDs).

10) The level of uncertainty in the standards of those in "area of need" registration is likely to be very high, given the diversity of backgrounds, training and experience of overseas trained doctors, as well as the variations in clinical responsibilities and supervision of area of need positions. It is essential that any

systems developed to deal with area of need registration are sufficiently flexible to allow for review and re-assessment in the light of performance monitoring.

The proposals outlined in this report for "area of need" registration have been developed as guidelines. It is important to note that the requirements of individual states and health services are different. These differences may require some variations in the implementation of the proposed system. Similarly, there are differences in legislative provisions for "area of need" registration and in the mechanism for determining that a position constitutes and "area of need."

The general principles for defining "area of need" registration categories and details of the administrative stages involved are set out in APPENDIX A. Examples of the three proposed categories of "area of need" registration are set out in APPENDIX B.

FUTURE CONSIDERATIONS

The system proposed in this report is an attempt to introduce a nationally consistent approach to the conditional registration of medical practitioners from "un-tested" backgrounds, including ROTDs who have not yet satisfied the examination requirements for general registration. The AMC feels that the present approach would provide a satisfactory mechanism for dealing with "area of need" registration, which could be developed over the next few years.

Amongst those involved in the development of this approach to "area of need" registration was the feeling that in the long term it would be desirable for all medical practitioners to be formally assessed or tested before being granted any form of registration. One option would be to develop a national licensing examination, such as the United States Medical Licensing Examination (USMLE), which could be administered to TRDs as well as ROTDs as a pre-condition for registration in an Australian State or Territory. However, the general feeling is that it would be premature at this time to adopt such an approach.

AUSTRALIAN MEDICAL COUNCIL
13 MAY 1996

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APPENDIX A

MATCHING "AREA OF NEED" POSITIONS TO OVERSEAS TRAINED DOCTORS

A. PRINCIPLES FOR CONSIDERATION

There are four dimensions that need to be considered:

Dimension 1: Definition of the Position

The level of responsibility of the job in question.

Here two components are envisaged.

1) The significance of the potential clinical responsibility involved, and this would involve:

   I. The level of seriousness of patient situations which are likely to arise.

   II. The probability of emergency situations requiring urgent decision making, and skilful and competent intervention.

   III. The probability of independent decision making.

2) The diversity of demand that may be required independently of those issues raised above. The issue of diversity of demand for skills and judgement is an important one. A job may have a low potential when judged by the criteria raised above, but nevertheless require skills across an array of disciplines for example; General Medicine; Psychiatry; Surgery and O&G; or alternatively a job may be very tightly defined in terms of patient characteristics and clinical situations for example, a doctor responsible for slow stream rehabilitation in elderly patients. In this latter situation the significance of clinical decisions is reduced because they are unlikely to be very often, of a life threatening nature, they would usually be of a kind to allow careful consideration over a reasonable period of time, and the diversity of patient characteristics may be low.

In summary this first dimension involves consideration of responsibility for the consequences of decision making which may be low or high, and diversity of clinical situations likely to be faced.

Dimension 2: Supervision

This is described by specification of degree of supervision and support.

In all cases we are assuming that someone, or a group, will take responsibility for some degree of supervision, and this will need to be specified by the category of appointment.

The dimension of supervision relates to three (3) factors:

1) The number of doctors "available" for informal discussions in a clinical situation. This is not the same as supervision. The doctors "available" do not necessarily have responsibility for the decisions that the appointed doctor makes. What is implied here, is the availability of doctors to take part in discussions - peer related considerations. There is also a need to consider the ability of the applicant to take part in such discussions. It should be noted that this level of supervision is not the same as "sharing responsibility". The applicant if appointed, would be responsible for the decision. It is also not the same as being "part of a TEAM, implying a team decision".

   It is an informal process which is a familiar one, at least to young Australian doctors, and one which is very important to short term patient care, and implies a competency in mutuality, communication and English language skills. In part, it is a cultural issue.

2) The next level of support is a judgement about the presence of, and quality of, a hierarchy or team. A potential appointee can be located within a hierarchy of decision making. In this context a judgement needs to be made about the clarity with which decision making is defined by the team. Here one is looking at the ease with which the day to day communications within the team would provide a level of informal, or implicit, supervision.

3) We are concerned with concrete and identifiable supervision which occurs over and above, or in conjunction with, or separate from, the two criteria provided above. Here there are formal undertakings by a supervisor about the nature, extent, and content, of supervision. This will be modified by judgements about the perceived competence, or skill, or experience, that can be presumed, about a particular applicant as a function of their assessment, and this may be modified as a function or monitoring of their performance.

Such supervision would usually take the form of regular feedback to the applicant and to the Medical Board, and the manner of this feedback may be very similar to that available to interns and residents in teaching hospital settings in Australia.

The form of feedback would need to be agreed as part of the conditions of limited registration, and it would be desirable that a uniform approach to such feedback is achieved across Australia. This might take three (3) to five (5) years to achieve and would involve such bodies as the postgraduate medical education groups

Dimension 3: Skills Required by the Position

These fall into two categories:

1) Communication skills address a level of mastery, linguistically, and culturally of the use of the English language. This can, in part, be measured by the fact of English being the first language of the applicant, or in part, by the level of competence measured in the English language skills component of the AMC exam procedures.

2) Formulation skills address a level of mastery of the ability to bring together the elements of a clinical problem, and to transmit this to another doctor or institution for example, under circumstances of seeking advice or transferring a patient. This can be measured at least in a supervised situation and would be a component of a pre-appointment assessment.

Dimension 4: Assessment for Registration/Appointment

<u>This dimension addresses competency.</u>

Competency can be measured in a presumed manner using conventional assessment techniques such as, reference and so on, which are outlined below, and can also be measured in supervised situations, and in monitoring.

In addressing this area we need to consider what measures are available to measure competency, and here we would include:

1) The extent to which the undergraduate degree of the candidate can be interpreted, in relation to Australian experiences.

2) The quality of the performance within the undergraduate degree of the candidate.

3) The equivalence of performance of an OTD graduate as a representative of his or her medical school in internationally recognised performance assessments such as, the ECFMG.

4) The quality of the postgraduate record:

- The relevance of the postgraduate record.
- References from undergraduate teachers or Deans of Medical Schools.
- References from postgraduate supervisors, peers and Heads of Departments. References from supervisors, peers or Department Heads in Australia or New Zealand, for clinical placements in Australia and New Zealand.
- References and assessments from trial placements in Australia and New Zealand for the purpose of assessment - and in this case it should be noted that it would not be sufficient for a

placement supervisor to record an experience "had occurred". Some degree of uniformity of assessment forms for supervised placement experiences will be necessary across Australia. This does not mean that the assessments need to be exactly the same, but they need to broadly cover the same concepts.

5) Level of performance in formal test situations in Australia and New Zealand including; the English language test; the MCQ component of the AMC; examinations in postgraduate colleges; and other recognised postgraduate experiences in Australia and New Zealand such as, the Diploma of Obstetrics and Gynaecology.

6) Performance in a formal interview could be taken into account.

What is being suggested here, is that there is an array of conventional methods of assessing the suitability of an applicant for a position and that these are uniformly, and usually used to some extent for the appointment of Australian graduates. This addresses the issue of discrimination. It is nonetheless true that the attaining of readily recognisable standards for safety and competence for overseas doctors, is more difficult than for Australian graduates, and that more material may be required to arrive at a conclusion about an initial placement, than might be the case for an Australian graduate.

All of this recognises that there may be additional requirements for overseas trained graduates compared to Australian graduates, simply because of the uncertainty about matters of standards. This means that other measures may need to be considered by Boards, and these might include:

1) A pre-appointment supervised experience. In this case the candidate may appear suitable for a high category of appointment, or at least a higher degree of appointment, but there may be a need for a trial period under supervision with specified criteria at a lower category in order to establish suitability.

2) It may be that deficiencies, or weaknesses, are potentially identified in the CV and a Medical Board might ask that these are addressed prior to appointment, and;

3) It may be that weaknesses are identified more formally for example, within the profile of the results of AMC MCQ exam, and directed and supervised experiences are required within the profile of a preliminary or final appointment situation.

B. AREA OF NEED REGISTRATION CATEGORIES

We present an array of categorisations of positions which vary as a function of responsibility, and of ability to assess appropriateness of matching. Each of these are linked to an array of assessment possibilities, supervisory possibilities, and monitoring possibilities.

In terms of the responsibilities, the nature of the service, the expected levels of competence, clinically expected levels of communication and formulation skills, and examples of the envisaged services, are provided. In terms of assessment, examples are given of the kind of track records, conventional measures, English language skills, AMC results etc, which might help to create a match. In any event where a match is recommended we are also giving details of the kind of supervision, monitoring and special conditions, that might apply at each category level of appointment.

For the purposes of discussion we have attempted to cover all possibilities in defining these categories. In its final form it may be possible to collapse some of these categories together and produce a much simpler system.

There are three registration categories as follows:

Category 1: Positions with Significant to High Levels of Clinical Responsibility

It is envisaged that the following types of positions/clinical settings would be included in this category of "area of need" registration:

A. Remote, isolated, mainly rural practice and sole practitioner.

B. Positions where the applicant would be the main decision maker for a team and would be either the Director or Team Leader.

C. A remote, or rural setting however, there would be a least one other experienced practitioner always present. It would be expected that the applicant would operate independently for example, alternate nights or weekends on, but the experienced practitioner would be available for advice, or under certain circumstances e.g. is a function of the linguistics of a clinical situation, be available for joint action. It would be expected that both practitioners would be of roughly equal competence, but not necessarily of equal experience.

D. Positions where the applicant would be one of the two, or more senior decision makers, of a team. The applicant would be expected to be part of a team where there would be; a senior decision maker; and where there would be rotation of staff; where the appointee would be a main decision maker; and have major and mainly personal responsibility for clinical decisions on a rotating basis.

Category 2: Positions generally equivalent to a 2 - 5 yr. RMO or FMP trainee in responsibility and diversity

A. The position requires the applicant to have moderate to high responsibility comparable to an Australian graduate of three (3) to five (5) years post internship, and that there would also be moderate to high diversity in the job.

B. The applicant would have high responsibility, but perhaps lower diversity for example, an intensive care unit, or alternatively high diversity, but perhaps only moderate of lower levels of responsibility for example, a position in a base hospital in a rural setting, which is also served by a large number of General Practitioners, but where the applicant could be on duty as the sole doctor, at night or weekends.

C. The position requires moderate to high responsibility as compared to a graduate from an Australian or New Zealand accredited medical school, with one (1) to three (3) years post intern experience, with moderate to high responsibility, and/or moderate to high diversity, or some variation of responsibility and diversity.

D. The applicant would have low to moderate responsibility plus or minus, low to moderate diversity, for a three (3) to five (5) year post intern position, or some variation of moderate responsibility and moderate diversity. A similar position, but where the equivalent post would be a post one (1) to three (3) year intern experience.

Category 3: Positions where it is not possible to evaluate qualifications or experience of the practitioner or where closer supervision is required

A. Posts equivalent to an internship with:

1) Moderate to high expectation in relation to rotations, in terms of organisation and decision making skills, and/or diversity of ability, or;

2) Moderate to high levels of both organisation and decision making skills and diversity.

The equivalent to an intern post, but terms are chosen, in part at least, for low to moderate expectations in relation to organisational and decision making skills, and/or diversity, and;

B. Some areas are directed by the Medical Board because of identifiable weak areas as judged from the Curriculum Vitae, references or other sources and/or the multiple choice questionnaire.

C. MATCHING POSITIONS AND INDIVIDUALS

It is envisaged that that there would be three stages in the "area of need" registration process:

Stage 1: Definition and Job Specification - Responsibility: Employer/Service Provider

ELEMENT	DESCRIPTION
Nature of Service	Defines the type of service provided by the area of need position - the level of clinical responsibility and diversity- the level of supervision available
Examples of Service	Illustration of the types of position eg. Remote/Rural, Neonatal Intensive Care, Accident and Emergency, etc.
Level of Skills Required for the Position	Defines the levels of skills expected in order to provide the service eg. Remote/Rural - High level of ability to communicate with other health workers by telephone.
Experience/Competencies	Defines level of experience or specific requirements for the position eg. Neonatal Intensive Care - sound knowledge of applied physiology

Stage 2: Assessment and Registration - Responsibility: Medical Boards

ELEMENT	DESCRIPTION
General Assessment of Applicant for Registration	Initial assessment by Medical Board using available information eg. references, rotation reports, evidence of basic and postgraduate training.
Formal Assessment / Evidence	Results in formal examinations eg. AMC MCQ examination in the case of ROTDs or results in comparable examinations such as the USMLE or PLAB in the case of TRDs.
Pre-Appointment Training and Assessment	The specific requirements of the position may require an applicant for registration to undertake a period of additional training, such as exposure to anaesthetics or an Aboriginal Health Service, prior to taking up the area of need position. The results of this Pre-Appointment Training could also be considered by the Medical Board in determining the suitability of the applicant for the position

Stage 3: Supervision and Performance Monitoring - Responsibility: Medical Boards and the Employer/Service Provider

ELEMENT	DESCRIPTION
Supervision	The type of supervision will be specified in the initial definition of the position by the Employer/Service Provider. Since the supervision is critical to the safety of the position, the Medical Board will need to be satisfied that supervision is in place. Specific provisions may vary from the use of the Rural Doctors Network to support Remote/Rural positions to the established monitoring provisions for RMO type positions in hospitals

Monitoring	Medical Boards may need to specify monitoring requirements in light of the particular features of the area of need position and the qualifications and experience of the individual practitioner. This may range from the standard performance monitoring arrangements in Hospitals to special arrangements for Remote/Rural positions.
Review and Reassessment	The "area of need" registration category may need to be reviewed in light of the performance monitoring and supervisors reports. This may include requiring the individual to work in a more closely supervised position or, if the reports are very positive, to be appointed to positions with less supervision and more clinical responsibility.
Special Conditions	Medical Boards should be able to set additional conditions or impose restrictions based on the performance reports or particular aspects of the area of need position.

The structured approach to "area of need" registration is illustrated in Appendix B with three examples of positions involving:

Category 1: An area of need position with a high level of clinical responsibility and limited supervision, such as a remote or rural practice;

Category 2: A position with moderate clinical responsibility and regular supervision, such as an RMO3 level hospital position

Category 3: A position with a low level of clinical responsibility and close supervision, such as an "intern" type position.

APPENDIX B

AREA OF NEED REGISTRATION
EXAMPLES OF STRUCTURED APPROACH

CATEGORY 1 AREA OF NEED POSITION - REMOTE/ RURAL POSITION WITH LIMITED SUPERVISION

STAGE 1: DEFINITION AND JOB SPECIFICATION

ELEMENT	DESCRIPTION
Nature of Service	High probability of emergency decisions. High probability of sole clinical responsibility. Wide spectrum of care needs by discipline - evacuation and retrieval services required. Largely independent - solo practice. Telephone communications for consultant support.
Examples of Service	Remote isolated rural practice/ Aboriginal Health Service
Level of Skills Required for the Position	High level of communication and formulation skills required.
Experience/ Competencies	Substantial evidence of specific and obviously relevant experience over time.

STAGE 2: ASSESSMENT AND REGISTRATION

ELEMENT	DESCRIPTION
General Assessment of Applicant for Registration	References specific to the requirements of the position and of good authority. Strong performance at interview (if applicable)
Formal Assessment / Evidence	Applicant falls within the top 20% of candidates at the AMC MCQ examination and has clear passes in all disciplines. (TRDs: High performance at the ECFMG/USMLE or equivalent examinations)
Pre-Appointment Training and Assessment	Optional - if required by the special nature of the position, eg. the need to familiarise the applicant with the Aboriginal Health Service.

STAGE 3: SUPERVISION AND MONITORING

ELEMENT	DESCRIPTION
Supervision	Remote and Rural Practice - may require special supervision arrangements - such as Rural Doctors Network
Monitoring	Periodic feedback to Medical Board through the supervision
Review and Assessment	If results of monitoring result in negative report on performance or safety Medical Board to consider change of area of need category to one involving a higher degree of supervision.
Special Conditions	Optional. Will depend on the circumstances of the position and the outcome of the monitoring.

CATEGORY 2 AREA OF NEED POSITION - TEAM SETTING WITH MODERATE RESPONSIBILITY

STAGE 1: DEFINITION AND JOB DESCRIPTION

ELEMENT	DESCRIPTION
Nature of Service	Equivalent to 1-3 year post-intern level position in a hospital or a GP practice. Clinical responsibilities include normal Obstetrics - management of chronic but mostly stable conditions, eg. diabetes Independent clinical decisions. Moderate diversity and responsibility - supervisor always available.
Examples of Service	Hospital positions at RMO3 level, eg. Obstetrics, Neonatal ICU with supervision, well supervised Accident and Emergency positions.
Level of Skills Required for the Position	High level of communication and formulation skills required. May require specific skills, eg. knowledge of applied physiology for Neonatal ICU.
Experience/ Competencies	Sound general experience in multiple rotations with moderate diversity and levels of responsibility.

STAGE 2: ASSESSMENT AND REGISTRATION

ELEMENT	DESCRIPTION
General Assessment of Applicant for Registration	References address general skills. Evidence from rotations.
Formal Assessment / Evidence	Applicant has clear passes in all disciplines at the AMC MCQ examination. (TRDs: Clear passes at the ECFMG/USMLE or equivalent examinations)
Pre-Appointment Training and Assessment	Not essential - may be required if there is insufficient evidence of the general experience or clinical responsibility of the applicant.

STAGE 3: SUPERVISION AND MONITORING

ELEMENT	DESCRIPTION
Supervision	This category of position is expected to operate in a team setting with supervision and other medical staff always available.
Monitoring **Review and Assessment**	Regular feedback to Medical Board through the established assessment and reporting provisions of the hospital. As for Category 1A positions. Medical Board may approve change to a registration category with lower supervision and greater clinical responsibility if positive reports of clinical performance are received.
Special Conditions	Optional. Will depend on the circumstances of the position and the outcome of the monitoring.

CATEGORY 3 AREA OF NEED POSITION - "INTERN" LEVEL POSITION

STAGE 1: DEFINITION AND JOB DESCRIPTION

ELEMENT	DESCRIPTION
Nature of Service	Intern-type rotation. Very low level of independent decision making - junior and senior supervisors always available. Team setting with very experienced nursing staff present.
Examples of Service	Hospital positions such as Accident and Emergency rotations.
Level of Skills Required for the Position	Level of communication and formulation skills expected of an Australian graduate intern.
Experience/ Competencies	Average general level of skills and medium to low diversity of clinical experience and responsibility.

STAGE 2: ASSESSMENT AND REGISTRATION

ELEMENT	DESCRIPTION
General Assessment of Applicant for Registration	References, if available, should address general skills. Likely that evidence of relevant experience will not be available. Structured interview is likely to be required.
Formal Assessment / Evidence	Pass at minimum performance standard of the AMC MCQ examination. (TRDs: Passes at the ECFMG/USMLE or equivalent.)
Pre-Appointment Training and Assessment	May be required if there is insufficient evidence of the general experience or clinical responsibility of the applicant, eg. if the performance in the MCQ is low in key discipline areas. May also be required if practitioner is moved in Category 7 because of a negative review in another category as a result of performance monitoring.

STAGE 3: SUPERVISION AND MONITORING

ELEMENT	DESCRIPTION
Supervision	This category of position will require close supervision.
Monitoring	Regular feedback to Medical Board through the established assessment and reporting provisions of the hospital or health care setting. Medical Boards may set specific reporting requirements depending on the qualifications of the applicant or following a negative report.
Review and Assessment	As for Category 1 and Category 5 positions. Medical Board may approve change to a registration category with lower supervision and greater clinical responsibility if positive reports of clinical performance are received.
Special Conditions	May be required depending on the circumstances of the position and the outcome of the monitoring.