Submission template

Public consultation on two further possible changes to the National Boards' English language skills requirements

The Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards (except the Aboriginal and Torres Strait Islander Health Practice Board) are inviting stakeholders to have their say on two further possible changes to the National Boards' English language skills registration requirements.

Please ensure you have read the public consultation paper before answering this survey. There are specific questions we would like you to consider below, including specific issues the Medical Board of Australia is asking its stakeholders to consider in relation to reducing the writing component from 7 to 6.5. All questions are optional and you are welcome to respond to any you find relevant, or that you have a view on.

We are not inviting further feedback on proposed changes to the National Boards' English language skills standards (the ELS standards) that we previously consulted on in 2022.

Your feedback will help us to understand what changes should be made to the ELS standard and will provide information to improve our other work.

Please email your submission to AhpraConsultation@ahpra.gov.au.

The submission deadline is close of business **Wednesday 13 September 2023.**

How do we use the information you provide?

The survey is voluntary. All survey information collected will be treated confidentially and anonymously. Data collected will only be used for the purposes described above.

We may publish data from this survey in all internal documents and any published reports. When we do this, we ensure that any personal or identifiable information is removed.

We do not share your personal information associated with our surveys with any party outside of Ahpra, except as required by law.

The information you provide will be handled in accordance with Ahpra's Privacy policy.

If you have any questions, you can contact AhpraConsultation@ahpra.gov.au or telephone us on **1300 419 495.**

Publication of submissions

We publish submissions at our discretion. We generally publish submissions on our website to encourage discussion and inform the community and stakeholders about consultation responses. Please let us know if you do not want your submission published.

We will not publish on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

We can accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information.

A request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or if you want us to treat all or part of it as confidential.

Published submissions will include the names of the individuals and/or the organisations that made the submission unless confidentiality is expressly requested.

Initial questions

To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☒ Organisation

Name of organisation: College of Intensive Care Medicine

Contact email: [redacted]

☐ Myself

Name: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes – publish my submission **with** my name/organisation name

☐ Yes – publish my submission **without** my name/organisation name

☐ No – **do not** publish my submission

Possible change one – Setting the minimum requirements for the writing component of an English language test from 7 to 6.5 IELTS equivalent and 7 in each of the other three components (reading, speaking and listening) with an overall score requirement of 7

One way to meet the National Boards' ELS standards is to achieve the minimum scores in an approved English language test. These tests assess an applicant's English language skills in speaking, listening, reading and writing.

The test pathway in the ELS standards is used by just under a quarter of applicants across the regulated health professions. National Boards currently require an overall score of IELTS 7 or equivalent but enable the scores of 7 in each component (writing, speaking, reading and listening) to be achieved over two sittings.

Question 1

Do you support reducing the score for the writing component of IELTS by half a band to 6.5 (or equivalent for other accepted English language skills tests) as proposed in the Kruk review? Why or why not?

Your answer:

The College of Intensive Care Medicine ('the College/CICM') has significant concerns about reducing the writing component of IELTS. Careful consideration of the proposed changes is needed to ensure there are not any unintended consequences for lowering/changing the competency requirements.

Additional considerations and questions for Medical Board of Australia stakeholders

The Medical Board of Australia has reservations about reducing the current writing component from 7 to 6.5 (IELTS equivalent) for applicants looking to register as medical practitioners in Australia as most comparable medical regulators require applicants to meet a minimum of 7. **Attachment B** of the consultation paper provides an overview of the scores comparable medical regulators from the United Kingdom, Ireland, New Zealand, and Canada require applicants to meet when sitting an English language test.

Question 2 (This question is most relevant to Medical Board of Australia stakeholders)

Do you have any specific views about the Kruk review recommendation to reduce the writing requirements for medical practitioners?

Your answer:

The comparison in Attachment B of the Consultation Paper shows that a writing score of 7 is required in UK, NZ, and Canada, and is 6.5 in Ireland

Lowering the score to 6.5 would put Australia below our peer countries (except for Ireland).

Writing is important in Intensive Care medicine because patient care occurs in teams, and it is vital for each team member to communicate their opinions, findings, and actions with other team members by writing in the patient's charts. Intensive care specialists are also required to document the content of family discussions clearly and accurately in the patient's record.

Furthermore, given the acuity of care required and the frequency of emergency situations in an ICU setting, clear and concise communication is critical. Additionally, ICU patient management is often time sensitive, and intensive care specialists do not have time to decipher what another doctor has written, as written communication in an ICU setting needs to be understood immediately.

The CICM would oppose any move to relax scores for speaking and listening as Intensive care specialists regularly have difficult and sensitive conversations with the families of patients in intensive care units (e.g., end-of-life care decisions and organ donation). Limitations in verbal communication could reduce the opportunity for goals of care discussions, lead to unnecessary use of resources and have an impact on donation rates. It is paramount that any reduction in language competency requirements will not negatively impact patients and their families.

Although there is less written communication between Intensive care specialists and patients, reducing writing requirements could still interfere with successful and sensitive communication with patients and their families. We are concerned that this reduction could represent the onset of weakening the overall standards which could later lead to reductions in speaking and listening proficiency.

Possible change two: Expanding the range of recognised countries where available information supports doing so

The countries that are recognised by National Boards in the standards have health and education systems largely equivalent to those in Australia. Health and education services in these countries are also typically delivered in English. This means National Boards can be confident that people who qualified in these countries have a level of English that is safe for practise in Australia. National Boards have significant regulatory experience with applicants from the countries recognised in the standard both before and during the National Registration and Accreditation Scheme.

The countries currently recognised by National Boards are one of the following countries:

- Australia
- Canada
- New Zealand
- Republic of Ireland
- South Africa
- United Kingdom
- United States of America.

A recent review of similar health practitioner regulators indicates there is an opportunity to expand the recognised country list to better align with UK and NZ. For example, the UK Visas and Immigration (UKVI) list or a comparative regulator like the UK Nursing and Midwifery Council (the UK NMC) recognised country list, indicate that citizens educated and working in those countries would have the English language skills needed for practice in Australia.

It can be complex to identify countries where the National Boards can be confident applicants will have the necessary English skills. The National Boards need objective evidence that applicants are able to speak, write, listen and read English to safely practise the profession. For example, if a country has multiple official languages, then English being one of the official languages means that the National Boards would need more information about a candidate's English language skills, not just their country of origin or education.

Question 3

Do you support adding proposed countries where evidence supports doing so as proposed in the Kruk review such as those listed in **Appendix A** of the consultation paper?

Your answer:

As none of the proposed countries (as listed in Appendix A) have intensive care training programs, any additions or amendments will have little impact on intensive care practice in Australia.

Question 4

Are there any countries missing from those listed in **Appendix A** where evidence supports inclusion?

Your answer:

None identified.

Question 5

If these two changes are adopted to the ELS standards, would they result in any potential negative or unintended effects for people vulnerable to harm in the community? [1] If so, please describe them.

[1] Such as children, the aged, those living with disability, people who have experienced or are at risk of family and domestic violence

Your answer:

As mentioned earlier, Intensive Care specialists primarily use speaking, listening, and reading skills to communicate with patients and their families.

Irrespective of this, the College is concerned that a reduction in writing standards would also negatively impact people who speak English as a second language, as they could find it more difficult to interpret and understand written communication when compared to those where English is their first language.

As such, this could inadvertently create more opportunity for miscommunication and misinterpretation of information when communicating with patients and families who are not fluent in English. As mentioned above, Intensive Care specialists regularly communicate difficult and emotionally sensitive information, so clear and easy to understand language is of the utmost importance.

Question 6

If these two changes are adopted to the ELS standards, would they result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

Any lowering of ELS standards would have potential negative effects for Aboriginal and Torres Strait Islander Peoples. Communication is a significant issue for Intensive Care specialists working in rural and remote communities with large Aboriginal and Torres Strait Islander populations. Although most communication with Aboriginal and Torres Strait Islander patients and families is verbal, written communication does sometimes occur and as such, this change could have a negative impact on patient care.

More than 50% of Aboriginal and Torres Strait Islander people in these communities speak English as a second or third language, and often require Aboriginal Interpretation Services or the assistance of Aboriginal Liaison Officers. Many of these interpreters and liaison officers also speak English as a second language. As such, communication needs to be clear and delivered in a culturally sensitive way, this could be negatively impacted if the standard was lowered.

Imprecise communication in this area will also impact relationships with Aboriginal Liaison Officers and interpreters, who are essential to ensuring culturally safe care of Aboriginal and Torres Strait Islander patients.

Furthermore, there are significant nuances in language when communicating with Aboriginal and Torres Strait Islander patients that are even difficult for doctors who speak English as a first language to understand. Given this, it would be even more difficult for doctors where English is their second language to understand how to communicate these nuances when communicating with Aboriginal and Torres Strait Islander patients.

In rural areas where there is more reliance on international medical graduates/specialists in the health workforce, there might be less opportunity for English mistakes and errors to be identified and addressed appropriately. There is also a higher potential for doctors with imperfect English to accidentally use offensive terminology or use terminology in an inappropriate way which would negatively impact Aboriginal and Torres Strait Islander people. While doctors who speak English as a second language often have better understanding of current medical terminology, they might find using easy to understand English slightly more difficult. This can be problematic when treating Aboriginal and Torres Strait Islander patients, as they will require simple English explanations to understand their care.