Stakeholder details

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 These details will not be published in any summary of the collated feedback from this consultation.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: Click or tap here to enter text. Contact email: Click or tap here to enter text. ☒ Myself Name: [redacted] Contact email: [redacted]
Question B If you are completing this submission as an individual, are you: ☒ A registered health practitioner? Profession: Radiologist ☐ 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

Your responses to the consultation questions

1. Is the content and structure of the draft revised specialist registration standard helpful, clear, relevant and workable?

It is helpful. It is clear.

As for if it is workable, I hold some concerns. See comments in 2 and 3.

2. Is there any content that needs to be changed, added or deleted in the draft revised specialist registration standard?

The specialist colleges have been assessing the suitability, and comparability of IMG doctors until now. If there is an alternative model/process, it must be performed to the same standard as the current process. For example, if there has been an established outcome, that IMGs from country X, due to their length of training, experience, examinations, mostly have a certain outcome, eg upskilling and/or examinations. In any new process, it would be entirely illogical, and I suggest unsafe, for similar IMGs, from Country X, to be given different outcomes, by virtue of now just undergoing a different "assessment process"

While the individual may not need to or be eligible for college fellowship, the individual must possess the same experience and capability (or superior) as if they were assessed by the historical college process. In no way, can any new process, allow a lower standard of medical practice/practitioner, to be compatible with any Standards of patient safety.

3. Are there any impacts for patients and consumers, particularly vulnerable members of the community that have not been considered in the draft revised specialist registration standard?

This new standard will require location specific conditions to be imposed, to ensure that our rural and vulnerable patients are not disadvantaged. This is particularly important as some countries which may be considered "equivalent health countries," on deeper review may not be so.

For example, if the IMG has trained and practiced in a country and has little (or zero) solo practice experience. The quantum of private practice of the IMG in their training and experience must also be evaluated, as practicing in a tertiary centre, supported by many colleagues/trainees, is vastly different from a solo private practice in a rural/remote regional clinic.

4. Are there any impacts for Aboriginal and Torres Strait Islander Peoples that have not been considered in the draft revised specialist registration standard?

See comments in other sections

5. Are there any other regulatory impacts or costs that have not been identified that the Board needs to consider?

The 19aa and 19ab sections of the medical act need to be maintained. If there is amendment, the risk that IMGs will preferentially choose metro regions. This will further exacerbate the workforce crisis in rural/regional areas.

Tele-health. I do not believe that any IMG, under this proposed process, should practice tele-health. While medicare prohibits services from being performed outside Australia, there should also be an exclusion that these IMGs practice tele-medicine/health (for private or international patients) in Australia only.

IMGs need to be supported by colleagues; they need to have face to face interactions with other members of the medical team, and medical colleagues (peers or referrers). This is of utmost importance for patient safety, as any shortcomings would be quicker to identify.

6. Do you have any other comments on the draft revised specialist registration standard?

While I support some aspects of this, and the Kruk review, to streamline and simplify the process for IMGs, my main concern is that of patient safety and practice standards.

We must not lower the standards of medical practice in Australia, ever.

We must not allow practitioners of a lower standard (than current), or those with less training and experience to practice on the Australian public.

I hold concerns that if these new standards are adopted, eventually, there will be 2 groups of specialist medical practitioners. One with college fellowship, and one without. There should not be "2 tiers" of doctors for our patients. While some may be of similar experience and ability, the absence of the college peer assessment, review, and accountability, is deeply worrying. There are significant nuances in training, experience, ability, that only peers can elicit and evaluate. The medical indemnity aspect of this eventuality would be interesting to observe.

I have 8 years of assessing IMGs qualifications, both as a college representative, and as a Department Director in a teaching hospital. My experience is that qualifications on paper, can be vastly different from the capability of the IMG. Any proposed "peer review" process, without college involvement, is often marred by conflicts of interest, and self-interests.