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3.07.24

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Professor Anne Tonkin
Chair Medical Board of Australia

Dear Prof Tonkin

Re: Request for public consultation, draft revised Registration standard, specialist registration.

The Royal Australasian College of Surgeons (RACS) welcomes the opportunity to provide feedback on the Medical Board of Australia (MBA)'s proposed revisions to the Registration standard: specialist registration and we are keen to work with MBA on ongoing development of this proposal. RACS is happy for this submission to be published via the MBA website or by other means. RACS looks forward to continuing to work with the MBA to improve the overall experience for SIMG applicants, and to assist in improving all Australians' access to high quality surgical care. RACS is committed to continuing to work with the MBA and AHPRA to ensure that SIMGs are delivering the high standards of surgical care that ensure the wellbeing of patients and the community.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education and Aotearoa New Zealand. It represents more than 8300 surgeons and 1300 surgical Trainees and Specialist International Medical Graduates (SIMGs), training in nine surgical specialties across Australia and Aotearoa New Zealand: Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery.

RACS notes that the Medical Board of Australia is proposing to establish an additional registration pathway (to be known as the expedited specialist pathway) that will lead to specialist registration and will sit alongside the current pathways. This is important work that RACS is committed to working on to develop and implement, in partnership with the MBA.

SIMG assessment is a high stakes decision for the SIMGs; for RACS; for regulatory authorities such as the MBA and AHPRA; for government; and for the community. Fellowship of the Royal Australasian College of Surgeons (FRACS) authorises doctors to provide surgical care anywhere in Australia across a diverse array of patient and variably resourced health services for any given scope of practice. Each SIMG, in any program or location, needs to know what skills they need to develop and the scope of practice they are working towards, based on context and community need (vocation and location). They also need to know the expectations required of them and that they will have the support needed to meet them.

The proposal states that the expedited pathway will be available to applicants who have been deemed to hold a qualification which is substantially equivalent or based on similar competencies to an approved specialist qualification for the specialty. RACS would like to continue to work with Australian Medical Council and the MBA to provide the list of qualifications and experience that are needed to be considered as substantially equivalent, implementing a review process in place that ensures list of qualifications remain current and up to date, in line with changes in Australian specialist practice and specialist training and assessment, as well as changes in each country's specialist practice and its specialist training and assessment programs. We also recommend that the MBA consider the addition of references provided by the SIMG to strengthen the initial stage of the process.

The current MBA standards for specialist registration are designed to ensure that each SIMG's training and assessment, recent specialist practice, intended scope of practice and CPD. At this stage the proposal does not clearly describe where consideration of recency of practice and intended scope of practice are considered within the SIMG assessment and the expedited pathway. Recency of practice is an important criterion in assessment of specialist comparability and in the case of specialist surgeons needs to be applicable to and aligned with specialist surgical practice, including criteria such as nature and type of clinical and consultative practice and scope of practice. These two essential criteria of recency and scope of practice enable comprehensive assessment of the SIMG and enable the supervised practice to be tailored to the needs and ability of each SIMG in their contextual setting.

All of this highlights the need for an individual assessment of each SIMG, rather than merely proof of holding a qualification.

RACS is happy to work with the MBA and AHPRA with particular focus on the 6 month probation period of supervised practice and the standards that will be employed during this period.

RACS notes that SIMGs undertaking the expedited pathway will be required to undertake a period of 6 months supervised practice in the specialty. This probationary period of supervised practice is a critical time in terms of ensuring safety and quality of clinical care and training for the SIMG. It is also a time for the SIMG to orientate themselves and become familiar with the Australian and local health systems and this transition experience often impacts on an SIMG's ability to demonstrate their full performance capabilities. It is unclear what happens, and who is responsible, if the SIMG cannot be properly supervised in the full scope of practice they want over the six-month period. RACS seeks further information on whether the supervisory time can be extended, the employment location changed and/or the scope of practice reduced? RACS is keen to work with the MBA to address these questions and ensure that the standards that support that supervised practice period are robust delivering the best possible outcomes for patients and their communities and SIMGs.

RACS is concerned that the shortened duration of 6 months for supervised practice seems like an intensive foreshortened training program and a post-entry rather than pre-entry intervention It has been RACS' experience that underperformance issues often only become apparent after an extended period of the SIMG working under supervised practice and may not be picked up in the initial 6-month transition period. There are a number of scenarios that need to be worked through in terms of unforeseen consequences, for example what happens if the SIMG demonstrates failure to progress during that six-month period and does not satisfactorily complete their requirements, including assessments and the health services wishes to continue to employ them? The governance issues in terms of responsibility and accountability for training and supervision during that supervised practice period need to be articulated for all parties involved and RACS is keen to work with the MBA in terms of governance of this new pathway.

The draft proposal does not currently include information on the cost of the expedited pathway, including the fees that will be charged for the SIMG and who pays for the supervision, the 6-month training program including assessments. How and when the MBA will resource this work is unclear. RACS would like to work closely with the MBA and AHPRA in development and implementation of this pathway to look at ways to minimise cost impost, particularly to ensure that the resources already being utilised within the current SIMG pathways and processes are not diminished or reduced in quality.

What has not been addressed is how this pathway be monitored and evaluated over time in terms of its outcomes. Will the MBA regulate the number of expedited SIMGs with respect to the workforce needs of Australia? It seems unlikely that some surgical SIMGs will ever work in areas of workforce need and this may create increased urban supply. This is an unintended outcome RACS would like to work with the MBA and AHPRA to avoid. The proposal does not describe how this expedited pathway will be evaluated and by whom and when, with what possible outcomes. RACS would be keen to work with the MBA and AHPRA to determine the key performance indicators (including workforce needs met and where) and the outcome measures that need to accompany implementation of this new pathway,

RACS is committed to working with the Medical Board of Australia to continue to improve its SIMG assessment processes and pathways, ensuring that the journey to fellowship for each SIMG is streamlined and well supported. We see exciting opportunities to utilise our experience and existing relationship with regulatory authorities such as MBA and APHRA and the Australian Medical Council, to further enhance new as well as existing SIMG specialist pathways and in turn ensure the wellbeing of patients and communities.

Regarding the specific feedback questions:

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

The document is not easy to read and comprehend, even for those with experience in the field. It must be even harder for a potential SIMG applicant. It could be improved with some simple flow charts or diagrams.

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

Eligibility under 58b for an expedited pathway will be clear, once a list of substantially equivalent qualifications is settled. However the draft document is not clear as to the requirements for supervised practice and RACS would like to work closely with MBA and AHPRA in development of the guidelines for supervised practice and in implementation of this pathway, with particular focus on the period of supervised practice.

The requirements under 58c are also unclear.

The document would be easier to follow if the requirements for 58b & 58c were written separately in each section.

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?

SIMGs in isolated rural areas may lack appropriate support and supervision. There is a risk that consumers who live in these areas may experience a lower standard of care than their urban counterparts. Practitioners in these areas arguably require a higher level of expertise, certainly not less.

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

RACS considers cultural competency and cultural safety a critical surgical competency. SIMGs come from multinational locations that do not have Aboriginal and Torres Strait Islander Peoples and as such need to learn about their health needs and how to treat them in a cultural safe way. This must be considered in the period of supervision being undertaken by the SIMG as lack of cultural competency can significantly impact health outcomes of our indigenous peoples.

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

As stated in the body of our response, there are a number of costs that have not been articulated in the draft proposal, including the costs to the SIMG, including whether or not the MBA will charge the SIMG for their part in the assessment? Who pays for the 6 month supervised practice period is not discussed and who pays if additional supervision time, assessments or additional support is required by the SIMG? The addition of an expedited pathway will also require resourcing by medical colleges such as RACS and how and when the MBA will resource this work has also not been described in the proposal.

What has not been identified in the proposal is the costs of unforeseen consequences of implementation of this pathway if it fails to deliver SIMGs able to practise at the level of a surgical specialist. If a SIMG is found during the period of supervised practice not to be practising at the required specialist practice level, this creates additional costs in terms of resourcing and support to minimise harm to themselves, their patients and their colleagues in the workplace. Who will fund that additional support is not made clear in the proposal. SIMG supervisors require training and support to undertake the supervision of SIMGs and the nature and level of support required when things go wrong escalates dramatically. Medical colleges like RACS provide a significant degree of support and training for supervisors as part of their role in determining and maintain standards of quality practice. RACS can provide valuable advice to the MBA which will help address these issues as part of working together on ongoing development and implementation of this pathway.

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

RACS believes that there will still be a need for individual assessment of a SIMG and can provide valuable advice to the MBA on the nuanced differences in training and specialist practice in other countries. It is important to note that UK fellowships do not imply UK training. This can be demonstrated by a CCT/CCST.

RACS is responsible for training in nine separate surgical specialties. UK/Irish training is nearly equivalent in most of these specialties however this does not apply in all specialties. For example, UK trained plastic surgeons are usually not trained in the management of facial fractures. UK trained vascular surgeons are often not as well trained in endovascular procedures as in Australia. There are also regional differences depending on which Deanery the training was conducted.

RACS looks forward to working with the MBA to further this important work.

Kind Regard,

Assoc Prof Kerin Fielding

President, Royal Australasian College of Surgeons