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 These details will not be published in any summary of the collated feedback from this consultation.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: Dr Milan Edinger-Reeve Contact email: [redacted]
Question B If you are completing this submission as an individual, are you: ☒ A registered health practitioner? Profession: Junior Medical Officer ☐ 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?

The draft revised specialist registration standard is too brief and requires more detail. A prospective list of possible alternative qualifications and why they are comparable would have been helpful with assessing the intent and ramifications for healthcare provision of this proposal.

I appreciate that the compressed timeline mandated for these changes may have impacted this, but disagree with the rationale for hastening due process.

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

Firstly, as an Australian junior doctor, I would have significant concerns practising under the supervision of a specialist without a fellowship from an Australian college. I would have concerns regarding the safety of my patients if management decisions were not made with reference to specialist training informed by local guidelines, epidemiology, interprofessional relationships and peculiarities of service provision and scope of practice shaped by our geographies and cultures.

If this must occur, I would at least be somewhat reassured if I knew that my supervising specialist had been assessed regarding the above aspects of healthcare delivery in Australia. Whilst the provision of training regarding cultural safety is potentially within the capabilities of the medical board, all other components measured above could only be safely assessed through relevant college exams.

For a competent, suitably qualified specialist from a comparable healthcare system, the capacity to pass relevant college examinations during a period of supervised practice should prove a very minor hurdle. I and the general public would have significant concerns if patient care was led by a medical professional who could not pass what is a basic assessment of competency to practise as a specialist in an Australian healthcare system. For this reason, I advocate that any SIMG should be required to pass all relevant college examinations to achieve expedited specialist registration by the Medical Board.

A grace period potentially including the period of supervised practice could serve to limit delays to workforce participation, but would have to be balanced against patient safety considerations.

Secondly, the addition of a qualification or competency to a list considered substantially equivalent to an approved specialist qualification should be predicated on reciprocal recognition in that other nation. This will ensure equity and adequate international standing of Australian qualifications. It would reflect poorly on our healthcare system, medical training and nation if Australian specialist qualifications were to be considered as de facto inferior to those of similar nations as a result of this revised registration standard.

This would also facilitate Australian specialists to more easily gain advanced skills and training overseas where the demand for such capabilities in Australia exceeds the capacity of the Australian healthcare system to train. This would substantially improve workforce shortages whilst providing optimal local workforce development - minimising long time reliance on SIMGs where the Australian government has limited influence over long term availability as a labour pool.

Finally, it has been well documented, including by multiple submissions in the Kruk report, that Australia does not have a net medical workforce shortage, but maldistribution of the existing workforce. The proposed changes do little to address the underlying factors governing geographic disparity in healthcare access. Beyond the medicare moratorium period these factors will affect expedited pathway SIMGs who bill medicare as a source of income just as they do locally trained doctors. Expedited pathway SIMGs who derive their income from non-medicare sources such as public positions will have little incentive to contribute to a solution as well. The only way to ensure that this revised registration standard actually addresses its primary rationale is to limit expedited pathway registration to areas of geographical need.

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?

Vulnerable members of the community are more likely to live and/or work in areas of need. This need would be more likely to be met by SIMG specialists approved under revision of the existing standard. My concerns regarding patient safety detailed in other responses would be particularly relevant to such vulnerable groups as a result.

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

Aboriginal and Torres Strait Islander Peoples are more likely to live and/or work in areas of need. This need would be more likely to be met by SIMG specialists approved under revision of the existing standard. My concerns regarding patient safety detailed in other responses would be particularly relevant to such groups as a result.

Furthermore, even with the provision of cultural safety and competency education packages, specialists approved under the new standard would still have the lowest levels of training and experience in this area of any comparable group in the workforce. Voluntary rather than mandatory association with Australian specialty colleges who do have specific expertise in cultural safety and competency with respect to unique aspects of specialist practice compounds this. The new standard would reinforce existing inequities in the provision of culturally appropriate care to Aboriginal and Torres Strait Islander Peoples.

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

Broad application of 'substantially equivalent or based on similar competencies' assessment without individualised evaluation of competency fails to account for diversity and rapid evolution of even very similar healthcare systems. For example, given historical associations and existing professional links, the United Kingdom is the natural healthcare system for comparison, and has a number of controversial alternative medical education pathways being developed that would likely not be comparable to Australian standards. This is in response to a failing and increasingly resource limited healthcare system.

Firstly, the introduction of Medical Doctor Apprenticeships would result in an MBChB qualification. Apprentices would work in non-clinical roles as clinical coders, porters and human resources administrators. This has been lauded as an attempt to improve equity of access to medical education with '20% work and 80% academia'[1]. Both I and the Australian public would have significant concerns that a doctor trained with at least 20% of their time taken up by tasks of low educational value such as moving hospital beds and equipment could ever be substantially comparable to an Australian trained medical officer.

Secondly the proposed introduction of a 4 year undergraduate medical degree[2] in the same country to 'reduce the challenge … of debt' would be unlikely to meet the expectations of Australian medical professionals and the public regarding the depth and duration of training they expect from their doctors.

Although both of these examples are relevant to the primary medical qualification of doctors, this is an example of rapid divergence from the standards of the Australian healthcare system in a comparable country. These less qualified healthcare professionals would receive similar qualifications to traditionally qualified practitioners and as such would be difficult to distinguish from appropriately qualified professionals without individualised assessment. It is difficult to exclude further major changes to

[1] Retrieved 01/07/2024 from https://heeoe.hee.nhs.uk/sites/default/files/medical_doctors_degree_apprenticeships_myths_and_facts_peter_bishop.pdf
[2] Rimmer A. Four year medical degree set to launch in 2026, says NHS England *BMJ* 2024; 385 :q1312 doi:10.1136/bmj.q1312

postgraduate and specialist medical training in similar countries that may exceed the pace of revision of the proposed standards. This would place patient safety at risk. Furthermore, one could reasonably expect such less qualified individuals to be overrepresented, as the broader factors necessitating this lowering of standards are a motivating factor for migration, as well as the desire to achieve accreditation before regulatory bodies respond to these changes.

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

I have significant disagreements with the broader context of the conduct of this review.

The abbreviated timeline provided for public submission is manifestly inadequate and has not been appropriately justified, to my mind, by the relevant minister. Political urgency should not be prioritised when there may be major unforeseen consequences to patient safety when alterations to the standards of the medical workforce are made

Whilst the findings of the Kruk report are significant, major elements of submissions made by professional organisations including RACGP, ANZCA, RANZCP and RANZCOG were ultimately not reflected in the final recommendations. These are the very bodies bypassed by the initial implementation of the proposed expedited registration process. This, therefore, does not reflect any type of consensus from the only organisations with relevant expertise to assess the quality and safety of training of medical practitioners in Australia. I recognise the time constraints regarding the development of the draft revised standard and have expressed my opinions regarding this above, but it is still surprising to me just how brief the rationale is for Medical Board to choose to revise this registration standard entirely.

I have significant concerns that the fragmentation of assessment of specialist medical qualifications will at best lead to unnecessary duplication of functions in a system where relevant expertise is already stretched thin. At worst, compromises will be made regarding the depth of involvement of personnel and organisations with the required clinical expertise to make such assessments and this will have profound consequences for the safety of ordinary Australians.

In summary, I oppose these regulatory changes on the grounds that they represent a risk to patient safety that has not been adequately explored, a loss of rigour in assessment of competency that could be streamlined through other means, it does not address the primary issue of workforce maldistribution that is the rationale for these changes, and has a foreseeable consequence of loss of international standing of Australian specialist medical qualifications.

As a doctor in training, I have observed that it is routine for us to spend multiple years in non accredited training positions, and a significant portion of our workload is taken up by tasks of little educational value. Money and time would be better spent removing bottlenecks and inefficiencies in Australian medical training in order to rapidly deliver excellent locally trained specialist doctors to the workforce.

If my views are not to be reflected in the outcome of this public consultation, then at the very least these risks could be partly mitigated by the following measures

1. Required expedited pathway SIMGs to sit relevant college exams within a specified time period, and exclude those who fail from specialist recognition.
2. Comparative qualification status should be contingent on reciprocal recognition in order to retain the international standing of Australian specialist medical qualifications and enhance local workforce training opportunities.
3. Expedited pathway registration should be limited to areas of geographical need.