Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
June 2023

Feedback on the Interim Report of the Independent Review of Overseas Health Practitioner Settings

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 5000 rural doctor members including over 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

ACRRM welcomes the opportunity to provide further feedback on the Interim Report (the report) on the Independent Review (the review) of Overseas Health Practitioner Settings. ACRRM would also like to thank the review team for the opportunity for representatives of our College to meet and discuss the report and its impacts. This submission addresses the report's key recommendations for our College and provides some additional information to assist with the further development work of the review as requested at these discussions.

It is recognised that the review is concerned with the process efficacy of the mechanisms by which Australia manages the skilled inward migration of medical and health practitioners. However, the outcomes of these changes can have profound implications both short and long term to access to skilled healthcare professionals for people in rural, remote, and other underserviced areas.

We would reiterate the importance that all recommendations of the report give careful consideration of their potential impacts upon workforce distribution both in the immediate and the longer term. It is crucial that they support the National Medical Workforce Strategy, Commonwealth Stronger Rural Health Strategy, jurisdictional workforce strategies and other key policy frameworks, toward delivering better health services for all Australians irrespective of their geography.

Additionally, we would stress the importance that the processes are viewed in terms of how they can support optimal outcomes toward recruiting practitioners attaining professional competency within their selected profession in the Australian healthcare system and establishing the personal well-being structures (particularly for doctors in isolated communities) that will underpin their best patient care and encourage them to stay in areas of workforce shortage.

With respect to General Practice applicants including for Rural Generalist positions a key element to attaining process efficiency and addressing rural and remote workforce goals is ensuring that our College is strongly embedded in the process and able to provide experienced and informed judgement about applicants' professional capacity as well as provide a smooth transition to membership of their profession with their fellow rural and remote practitioners.

Response to Interim Report Recommendations

Improve the applicant experience (I)

Recommendation I5: Suspend labour market testing for high priority professions

Working on the assumption that General Practice is considered a high priority profession, this recommendation has a high risk of creating an unintended consequence of further exacerbating workforce maldistribution unless there are also strong workforce distribution policies in place to ensure any additional workforce flows to the communities of absolute highest priority, namely rural and remote towns.

There is a national health cost associated with each additional practitioner in Australia. If recruited practitioners (even in professions of national shortage) are only supplying their services in localities that are already adequately supplied and not providing services to underserviced populations than these appointments will not address needs and will present an opportunity cost to financing services where they are needed.

Identification of workforce needs requires a more nuanced approach than simply identifying specialties of national workforce shortage. Rural and remote models of care should be taken into account when considering rural and remote populations' needs. Workforce modelling is predominantly based on urban contexts where patients have access to a wide range of specialised healthcare services. In rural and remote areas healthcare gaps are often filled by teams of healthcare practitioners working in distinctive models of care. Extensively across Australia Rural Generalists work in local healthcare teams provide general practice clinic services as well as being key contributors to the provision of such services as anaesthetic, obstetric, emergency, in patient, palliative, mental health and population health care.

For example, while Psychiatry is an identified area of significant national workforce shortage, Rural Generalists and other General Practitioners, Nurses and Counsellors actually deliver the bulk of rural and remote people's mental healthcare. As such increasing the number of psychiatrists and particularly sub-specialist psychiatrists may not be the best approach to improving rural access to mental healthcare. Rural Generalists with advanced training and skills in mental healthcare (i.e. acute, emergency and chronic care) supported by appropriate skilled nurses and allied health professionals may be a better workforce solution.

Australia's overall doctor to population ratio is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply.[1] Maldistribution of the medical workforce however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. These shortages are contributing to unacceptable inequities in terms of healthcare outcomes for the people affected by them.

As previously highlighted in our Submission[2] to the review, geographic maldistribution, the imbalance between specialist disciplines, subspecialisation and generalism and the need to move away from reliance on locums and international medical graduates are all documented in the National Medical Workforce Strategy 2021-2031.

Recommendations I6 and I7 Remove age exemptions and allow to work broader scope of practice than indicated on visa, but comparable to scope in home country

The proposal to allow work to a broader scope than permitted on the visa, subject to the approval of the applicant and the employer appears to place excessive risk on the employer particularly given the diversity of applicant's professional backgrounds.

We would see potential for a role for the professional colleges in certifying or supporting this broader scope including through professional development systems. ACRRM Fellowship has been designed based on a recognition of the unique and extended scope of practice that many generalist doctors practice in rural and remote areas to enable their communities can access to needed services. The Fellowship curriculum and training programs have been designed to ensure these doctors are trained and their competency is assessed and certified to this broader scope. Engaging our College in this process will enable a streamlined process which is built on well-established systems and ground level experience of the work environment.

The College supports removing the age restrictions.

Recommendations I10: Grant automatic residency to international students with priority health qualifications and I12: Broaden visa categories to allow health professionals to work to full scope of practice

It is noted that this recommendation is unlikely of itself to positively influence workforce maldistribution particularly as the vast bulk of training occurs in cities and graduates are most likely to opt to work in their place of training.

Additionally, it is noted that this approach has the potential to be subject to gaming and the university and vocational training system may become viewed as a mechanism to circumvent standard immigration processes. While this would be beneficial in the short-term this may over time create an inability to manage the healthcare workforce.

It is recommended that automatic residency to international students if it were to be conferred, should only be conferred to students making some form of commitment to practice in geographic areas of underservicing. It is further recommended that any changes made in this area are implemented to ensure they are short-term and not inadvertently embedded into systems.

Expand "fast-track" pathways (F)

The College is dedicated to ensuring that rural and remote communities can have confidence that their practitioners are fit to practice safely and to a high standard. ACRRM is aware that there have historically been instances where the processes for assessment of the fitness to practice of doctors

[1] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.
[2] Ref Fn 1

recruited from overseas, particularly in areas of high workforce shortages such as rural and remote areas have not been sufficiently robust with negative consequences for patient's safety of care.

The College considers that the current assessment processes related to the medical practitioner's capacity to practice safely in rural and remote areas are generally sound. ACRRM recognises that there is always opportunity to further streamline and automate appropriate administrative process and would support any opportunities where this can be achieved with no trade-off to patient safety.

Recommendation F5: Transition equivalence assessment from Specialist Colleges to AMC

Contrary to the stated rationale for this recommendation it is our expectation that the proposed transfer of the role of assessor to the AMC would be likely to increase the administrative burden, timeframes and total cost for candidates to achieve Fellowship.

ACRRM has a well-trained pool of experienced and expert rural doctor SIMG assessors, pragmatic and highly efficient assessment pathways in terms of both time and cost for applicants. We have developed and publish contemporary lists of comparable authority programs (CAPs) and qualifications that we consider to be substantially equivalent to our own Fellowship. We also have robust processes for reconsideration, review and appeal that are available to candidates if required.

Our College SIMG assessment process is deliberately designed as a single, integrated, assessment of suitability for specialist medical registration and suitability for conferral of Fellowship, The proposed transition to AMC-based assessment for registration purposes would therefore introduce a need for candidates to undergo subsequent additional assessments, administrative duplication and cost to subsequently apply to the College for Fellowship to attain professional and peer recognition within Australia.

Organisationally, ACRRM's current SIMG assessment management synergises with the expertise and systems the College already has in place for Australian Medical Graduates. For Partially Equivalent SIMGs in particular there are many benefits of being able to leverage the resources of the ACRRM Fellowship training, in particular being matched with designated medical educators, supervisors training support staff, professional communities of practice, and networking/education events. SIMG doctors' benefit from the experience of being part of the College and can seamlessly progress to CPD with ACRRM as Fellows.

These supports and opportunities to network and engage with their new professional community are important for all practitioners but especially important for SIMGs working in rural and remote areas. It is recognised that overseas trained doctors experience higher levels of personal and professional stress relative to other rural and remote doctors.[3] Not only do they experience the challenges associated with practicing in a new culture, a new national health system and often in their second language, but over and above this they experience the stress of working in the relative professional isolation of rural and remote settings and the elevated professional responsibilities and expanded scope of practice that this typically entails.

The College strongly recommends that this proposal not be adopted, or at least not adopted universally for all specialities. Should Recommendation F5 be implemented however, the College considers it imperative that alternative mechanisms are established to ensure that these doctors are linked into their new professional associations through a formal process of training, professional development or skills certification as appropriate.

[3] Wearne S, Brown J, Kirby C, Snadden D (2019) International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor? *Medical Teacher* 41:9, 1065-1072, DOI: 10.1080/0142159X.2019.1616681

Recommendation F6: Better recognise overseas health practitioners' experience/skills skills/experience included in clinical competency assessment (not just qualifications) – requires amendment to National Law and* F7 *– Ahpra, National Boards and specialist colleges to increase the use of existing powers to provide limited registration and Fellowship for highly skilled and experienced health practitioners who wish to work to a limited scope of practice

The College supports these recommendations in principle but recognises that their efficacy will be largely contingent on the detail of how they will be implemented. We note that Colleges will be a key part of the proposed changes and we look forward to providing further feedback as further details are available.

Recommendation F8: Target scarce supervisory resources to where they are most needed – develop online modules and a mentoring model

This is best achieved through the Colleges as part of usual training and mentoring pathways.

It is imperative that workforce strategies and policies integrate meaningfully to ensure Australian Graduates, Foreign Graduates of Australian Medical Schools (FGAMS), and IMGs are well supported to meet the needs of our rural, remote and Indigenous communities in Australia. Far more needs to be done to ensure IMG and FGAMs receive more equitable financial, personal, and professional support to succeed and thrive in rural medical careers.

Current policy settings that exclude FGAMS and IMGs from applying to access commonwealth-funded general practice training positions on the Australian General Practice Training Program and Rural Generalist Training Schemes should be urgently revised to remove barriers to rural training and support while they work to achieve Fellowship.

Financial support schemes, such as income-contingent loans that are available for students in Australia's higher education sector, could also be considered to assist to buffer the substantial income disparity, assessment fees and relocation costs for IMGs and their families as they transition into rural and remote communities in Australia. Similarly, access to Medicare should be provided for IMGs and their families once they commence work in any part of Australia's health care system. It seems abhorrent to reason that those delivering the care in our most needy are themselves not eligible to receive the same level of support and care as others in that same community.

To avoid duplication and to harness the opportunity to integrate SIMGs into their local professional networks, we would strongly recommend that the targeted resources and initiatives associated with this Recommendation build on the resources and programs already being delivered by ACRRM and other Colleges.

Recommendation F15: Target scarce supervisory resources to where they are most needed – explore expanded remote supervision models (Canada allows almost all supervision of doctors to be provided remotely)

Our College would be well placed to lead work in the development of these models. ACRRM already has in place bespoke guidelines for remote supervision and has been developing and refining best practice approaches to safe remote supervision in its accredited Fellowship programs for decades. It has also pioneered remote and workplace-based assessment approaches such that it experienced no interruption to its assessment programs throughout the COVID-19 lockdowns. ACRRM was founded specifically to enable and set standards for safe, quality training for doctors working in rural and remote areas over a quarter of a century ago.

It is proposed that the review consider investing ACRRM as a lead in a collaborative process to develop these models. The College would welcome the opportunity to discuss this further.

Improve Workforce planning (W)

Recommendation W1: Quantify workforce, skills, and distributional issues – better coordination with commonwealth and jurisdictions to model, identify and address workforce gaps

ACRRM welcomes these recommendations and would reiterate the imperative that these models are carefully constructed and do not serve to inadvertently exacerbate current distortions. We suggest this recommendation be flagged specifically as part of the National Reform of Health Care Agreement consultation that is in progress and nearing completion.

As stated in our earlier Submission, there is currently a severe workforce maldistribution which is having a direct and unacceptable impact on the health and well-being of people living outside major cities. This maldistribution is leading to a regressive allocation of the national health spend which is exacerbating the country's socio-economic and health inequities.

As outlined at Recommendation I5 above, the College would caution against an approach to skilled immigration as workforce lever without robust workforce distribution policies and support programs in place to mitigate against the risk of oversupply in urban centres, and:

1. ***Viewed skills shortages at the national level without identifying the geographic distribution of shortages.***

   The workforce distribution should be incorporated into all measures of workforce need. Furthermore, it is imperative that the merits of any policy instruments as workforce levers are considered in terms of the geographic distribution that can be expected of the skilled migrants that are supported.

2. ***Views workforce shortages in terms of the number of practitioners within specified specialist professions without consideration of the diversity of models of care that operate to provide healthcare services.***

   Many rural and remote people cannot realistically access many specialist consultant medical and allied health services. This is evidenced by patterns of usage showing, compared to levels in major cities, annual utilisation of non-GP specialist services decreased by 25% in outer regional areas and 59% in remote and very remote areas.[4] This being the case, it is important that need for alternative 'rural' professionals with scopes of practice appropriate for rural and remote contexts should be recognised and incorporated into workforce modelling and planning.

It is important to recognise that Rural Generalist Medicine is currently being assessed by the Medical Board of Australia for formal national recognition as a specialist field. As such current national workforce models do not incorporate or measure the available of Rural Generalists with assessed advanced skills and training in areas such as obstetrics, anaesthetics, emergency medicine, mental health care, palliative care, and public healthcare.

It is essential that the key role in rural service provision of Rural Generalists, their nationally accredited scope of practice, and the opportunity to recruit doctors with these skills, is incorporated into planning and modelling.

[4] AIHW (2021) Medicare-subsidised GP, allied health and specialist healthcare across local area: 2019-20 to 2020-21.

Recommendation W 2: Help industry and service providers to better plan – KPIs of progress in recruitment of OTDs for high need areas by June 2023

As outlined at W1 above, it will be important for these KPIs to be linked to geography and not just to professions and to recognise the common models of practice in rural and remote areas and their associated distinctive workforce requirement including for Rural Generalist doctors and for other healthcare team members with similarly broad scopes of practice for rural settings.

ACRRM strongly supports the establishment of target metrics relating to IMG workforce development, however, we note the very tight timeframe in the recommendation and believe there would also be benefit in extending this timeframe to Q4 2023 to provide sufficient time for appropriate consultation and agreement on monitoring and measures.

Recommendation W5: Inform the development of national cross-sectoral workforce strategies – Commonwealth and jurisdictions to explore rotating new OTDs from urban to rural settings

Further detail is required in relation to this recommendation. The provision of essential medical services in many rural and remote areas continues to rely heavily on active recruitment of doctors from overseas, usually through recruitment policies which specify their practice in areas of service shortage.

It is important that initiatives are cognisant of potential perverse consequences:

- The expansion of the Distribution Priority Areas (DPA) scheme in 2022 to address proportionately smaller workforce shortages in MM2-1 areas triggered significant movement of IMG doctors out of MM3-7 and has made it substantially harder to recruit to MM3-7 vacancies.[5]
- Initiatives to bring more doctors and other health practitioners into the country will increase the national healthcare spend with the associated opportunity costs, and they may exacerbate over-servicing in some areas, without necessarily providing services where they are needed.
- We would also acknowledge the broader international responsibilities of our country to not build a national workforce strategy intrinsically reliant upon negatively impacting on the health services of other countries and particularly, lower-income countries

The College would also highlight the risks associated with sending urban practitioners to rural and remote clinical settings without appropriate skills and experience, preparatory training, orientation, handover, and in-practice support. ACRRM would be pleased to work with the review team to discuss how this may best be achieved and would see a potential role for the College in this space.

Greater flexibility while supporting safety (S)

Recommendations S7-9: Changes to English language requirements Reduce IELTS writing score minimum standard, but maintain reading, speaking, listening. Include more countries as recognised English language jurisdictions

ACRRM recognises the importance to the safety and quality of healthcare for people in rural and remote communities that they are served by doctors who understand what their patients are saying, and who are able to be understood by their patients. The College has some concerns regarding the proposal to lower the current writing standards. Any changes to standards or current testing regimes should continue to prioritise patient safety for effective consultation-based communication and written skills of the practitioner.

[5] Sparke C (2023) '800 open job ads 'a sign of rural doctor crisis' *Australian Doctor.* 21 Feb 2023 https://www.ausdoc.com.au/news/800-open-job-ads-a-sign-of-rural-doctor-crisis/

Recommendations S10-11: Consider greater flexibility to demonstrate recency of practice – to be assessed by Ahpra and National Boards

ACRRM supports these recommendations in principle and would view it as important that Colleges have a role in identifying the appropriate alternative benchmarks to ascertain a practitioners' competency within both professional (scope of practice and model of care) and practice location context (geographic isolation and clinical capability/facilities of practice).

Recommendation S12: Expand testing options and access for applicants – develop online clinical examination with offshore processing capacity

This should require Colleges as experts in specialist Fellowship particularly in the development stages.

The pandemic experience has driven substantial progress in distance-based methodology and delivery for assessment and this should be leveraged to develop more time and cost-effective approaches especially for doctors in rural and remote areas. It would remain important to keep the nexus of processing in Australia to ensure appropriate operational oversight and system consistency.

IMG Standard Pathway for registration: ACRRM Pre Employment Structured Clinical Interviews

The College is an AMC approved provider of Pre-Employment Structured Clinical Interviews (PESCIs). It has been delivering accredited PESCI assessments since their inception, commencing in 2009 in Queensland, and in 2012 expanding these to be delivered across all states and territories. Over this time, it has built a pool of over hundred trained interviewers and a continuously reviewed bank of questions.

PESCI assessments form part of the MBA process for assessing non-specialist IMGs applying for registration via the Standard Pathway. PESCIs provide a fitness for task assessment which assess competency for safe practice within an identified position of employment at which applicants will work. The College understands the majority of IMGs working in general practice and primary care settings throughout rural, remote and Indigenous communities in Australia are initially assessed and registered to practice via the Standard Pathway. This makes a focus on the Standard Pathway intersections with the general practice workforce essential to any reform agenda designed to create impact.

ACRRM PESCI assessments comprise an eligibility check, a panel interview and subsequent assessment of competency against the exigencies of the identified position. The panel comprises two experienced ACRRM Fellows and a Community Representative. All three receive training in the PESCI interview, the panel lead will have extensive experience and will draft the assessment report with input and final approval from the other two panel members.

Applicants may be deemed appropriate to work at this position from level 1 to level 4 supervision. In more recent years the College has pivoted to providing the option of undertaking these interviews online as well as in person. Further information on the College PESCI process is available at the College website.

ACRRM contends that with over a decade of operation, it is timely to review the design of these processes particularly with the benefit of the experience and learnings of organisations such as our College.

Some of the issues that the Colleges recognises and continue to seek to address with the PESCI concept would include:

- PESCIs are expensive to run and intensive in terms of their reliance on the participation of busy people. The program involves extensive training to acquire the pool of appropriate doctors and community representatives necessary to carry out the interviews. It also draws considerably upon these people's time. Particularly in the case of experienced rural doctors, time is limited, and availability can be unpredictable due to unexpected local clinical demands. These issues have been somewhat mitigated by the increased number of online PESCI assessments being conducted.

- The interview dynamic is complex and outcomes subject to influence by the particularities of the individual participants and their interactions. This is offset somewhat by having a panel of three, providing consistent panel training, and having one member of the panel (the lead) who provides a consistent perspective across interviews.

- There is a trade-off that must be managed between the relevance of questions and acceptable responses to the context of workplace and level of supervision and maintaining consistency and reliability of questions and expectations for demonstrated competency against these. Managing this tension is a key role of the lead interviewer.

- The high stakes interview modality may create disproportionate stress for some applicants which may not be representative of their capacity in an actual workplace scenario. Notwithstanding the importance of doctors having strong conversational skills and also being able to operate effectively in stress situations, it should be noted that additional stress in high-pressure assessment hurdles, particularly where these are conversation based, may be disproportionately impactful on applicants who are older and those who speak English as a second language.

- PESCIs are ultimately based on an interpretation of the MBA standard which leaves considerable scope for subjectivity. This is of itself problematic as it lends scope for individual biases. It is particularly problematic given the recent moves to publish PESCI results for the benefit of prospective applicants creating market pressure to interpret this standard at its lowest.

Based on our College's experiences we would make the following suggestions that might guide further analysis.

- **Workplace Based Assessments**

  In conjunction with the AMC, ACRRM conducted extensive pilots of Workplace Based Assessments(WBA) associated with the Competent Authority Pathway doctors considering working in general practice over 2010-12. The AMC ultimately took a conservative view of these and did not encourage a national roll out at that time. Their position was based primarily on a lack of confidence in assessment based on virtual interactions and also around concerns regarding Conflicts of Interest of requiring onsite supervisors in general practice (many of whom were also the IMG's visa sponsor and employer) performing assessment functions. Whilst there is an option for some IMGs in the Standard Pathway to have their clinical skills and knowledge assessed in the workplace by AMC accredited providers as an alternative to the AMC Clinical Examination, the program is not available to IMGs working in general practices, Aboriginal Community Controlled Sectors or other community care settings. Consideration should be given to revisiting this model as WBA is more entrenched in medical education and training and supported in literature than it was in 2010. These could easily be conducted remotely and ACRRM would be keen to resume its leadership role in this space.

  The widespread adoption now of online based assessment would clearly allay concerns with respect to the former issue. On the issue of Conflicts of Interest, we would see these concerns as legitimate but manageable. They could be addressed at minimal expense and administration in multiple ways. For example, by bringing in additional assessors/observers via online mechanisms, or by supplementing the assessment with an additional online hurdle

such as the ACRRM Multi-Source Feedback which has now been a routine part of ACRRM Fellowship assessment for over a decade.

- **Clarity of Accreditation Standard**

  It is recognised that the pass rate is low across the country and subject to considerable variation. This may well reflect the variability in the calibre of candidates and also the degree of professional challenge inherent in the employment position being sought. This does however raise concerns about the reliability of application of standards across accredited assessors particularly where in the corporate sphere there is incentive towards lowering standards. We would see value in providing a clearer definition of the assessment standard and some broad national discussion forums and resources to support consistent understanding and application of this standard. Consideration could be given to using the Behaviourally Anchored Rating Scales (BARS) scoring approach, which is based on descriptors of behaviour rather than checklists.

ACRRM Reciprocal Arrangements

The College has in place a range of reciprocal arrangements with varying degrees of formality.

- A formal reciprocal relationship between the Fellowship of ACRRM (FACRRM) and Fellowship of the Royal New Zealand College of General Practitioners (FRNZCGP) established via a Memorandum of Understanding since 2012. This was supported by an *Ad Eundum Gradum* relationship ratified by the AMC in 2012.

- A similar reciprocal relationship was established between the FACRRM and the Fellowship of the Family Physicians of Canada (CCFP) (post 1992) in 2011 which was also ratified by the AMC in 2012.

- There are a number of countries such as the United Kingdom whose processing authority (i.e. the General Medical Council (GMC)) recognise the FACRRM as meeting the AMC standards for specialist general practitioners, and such recognition enables some expedition of assessment. In turn, ACRRM has a codified list of countries for which it offers expedited processes of assessment which was most recently reviewed and updated this year. There is some scope on a country-by-country basis to simplify processing of applicants certified in these countries in alignment with specific agreed arrangements. The list and the related arrangements are published on the College website.

Under the current arrangements the College has scope to assess comparability with the ACRRM Fellowship from the first point of contact with applicants for the Specialist Pathway and from the outset can direct any applicant deemed comparable on the shortest possible pathway to ACRRM Fellowship including (where applicable) directing them to apply immediately for Fellowship.

From the point of assessment, these doctors will commence their engagement with key college staff and senior clinical leads, such as medical educators, censors, etc. They will become full members of the College with access to College educational resources, learning events, including PDP and Fellowship education events that may occur in their regional area, and networking opportunities. They are designated a Medical Educator who will help them design a bespoke learning/assessment pathway to Fellowship.

In the event that Specialist Assessment were managed by the AMC:

- This essential process would no longer be conducted by the recognised arbiters of expertise in the ACRRM Fellowship and scope of practice (i.e., the College) which is the basis for

national quality standards. It is noted that this could be managed in a two-step process where the AMC seeks the advice from the College however this would appear to represent a further complication to processes rather than streamlining.

- The opportunities to optimally streamline each doctor's pathway to Fellowship will be lost noting that the AMC does not have expertise or stewardship of management of progression through assessment to ACRRM Fellowship.
- The cumulated knowledge and expertise of the College in processing these assessments (noting that this in reinforced through the Colleges work in PESCI assessments and Fellowship assessments) will be lost to the process.
- The unique opportunity for doctors to become part of their professional association and leverage the benefits to smooth their transition personally and professionally to living and working in Australia would be lost. This would include opportunities such as mentoring, bespoke information and resources, and social supports. These are important for all new doctors but particularly important for the many doctors who will be recruited to practice in the relative professional isolation of rural and remote Australia.

College Details

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.