Committee of Presidents
of Medical Colleges

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Submission to the Senate Community Affairs Committee Inquiry into

National Registration and Accreditation Scheme for Doctors and Other Health Workers

This submission has been prepared without the benefit of access to the draft principal legislation ('Bill B') which will prescribe the arrangements for the establishment and operation of the proposed national system of registration and accreditation of the Australian health workforce. As the Bill has not been made available, it has not been possible to be as specific as would otherwise be the case as it is not known what notice, if any, has been taken of advice provided in earlier submissions made in response to 'consultation documents' circulated. Copies of this organisation's earlier responses to those documents are attached as Appendix A (Registration Arrangements), Appendix B (Accreditation Arrangements) and Appendix C (Registration of Specialists).

Summary

The following issues are dealt with in greater detail in this submission -

- any proposed new system of medical registration or accreditation must ensure that patient safety and the quality of patient care provided to all Australians is not reduced or compromised in any way;
- there is a serious risk that jurisdiction responses to health workforce pressures will lead to a reduction in the quality and safety of patient care, through the use of under-trained healthcare providers outside of their proper scopes of practice;
- the Committee of Presidents of Medical Colleges (CPMC) supports the concept of a national registration scheme for medical practitioners;
- in the interests of public safety, a specialist register for medical practitioners (as exists currently in four jurisdictions) should be retained in the new registration system, rather than the specialist 'endorsement' arrangement proposed;
- the recommendation of the Productivity Commission, that the registration and accreditation functions for the health professions should have separate governance arrangements, is sound and should be adopted;
- the introduction of a national accreditation scheme should be considered separately and should not proceed until the registration system has been implemented successfully and is operating effectively;
- the medical accreditation body must remain independent from any outside influence, including from influence or interference in its decisions by any level of government or any government-established body, in discharging its responsibilities;
- the medical profession would reject any measure introduced into the proposed national accreditation arrangements which would lead to any reduction in the Australian Medical Council's autonomy, independence or effectiveness; and
- the medical profession's views have been disregarded consistently throughout the development of the Intergovernmental Agreement and subsequent draft legislation.

Introduction

The Committee of Presidents of Medical Colleges is the unifying organisation of and support structure for the 12 specialist Medical Colleges of Australia. The CPMC seeks to ensure that individual medical specialties (including general practice) have a broad base of intercollegiate knowledge so as to enable them to provide for the Australian community the highest quality of medical care delivered in accordance with accepted clinical principles and to improve, protect and promote the health of the Australian public.

The individual member Colleges are responsible for the determination and maintenance of standards for their respective disciplines and for the training and education of medical specialists in that discipline.

The CPMC is also involved in policy development and, as the peak specialist medical body in Australia, provides objective advice on health issues to Government and the wider community.

General Comment

The CPMC has long supported the concept of a national registration scheme for medical practitioners which would -

- ensure that patient safety and the quality of patient care provided to all Australians is not reduced or compromised in any way;
- facilitate the ready movement of registered practitioners across Australian jurisdictional boundaries;
- be supported by nationally uniform policies and regulatory guidelines and not rely on mutual recognition of jurisdiction-based registration; and
- protect against unilateral departures from uniformity over time by individual jurisdictions as political responses to subsequent events within those jurisdictions.

At the same time, the CPMC has asserted strongly from the outset that the basic principle underlying any new system of registration or accreditation must be that patient safety and the quality of patient care provided to all Australians must not be reduced or compromised in any way.

The CPMC has expressed its concern regularly that the authors of the Intergovernmental Agreement (IGA), during the development of that document, ignored the clearly expressed view of the Productivity Commission that the registration and accreditation functions for the health professions should have separate governance arrangements and paid no regard at all to similar advice tendered by representatives of the professions involved. At no time during this COAG process have the IGA authors provided any cogent or compelling explanation of their determination to combine the functions of registration and accreditation, which are separate and distinct in their objectives and purposes.

The only response given is that combining the management of the two functions would be more cost effective. This is highly debatable if the current AMC model were to be retained. There is a growing belief within the medical profession that the real reason is ideological and, more worrying, a quest for additional government control of accreditation processes and standards.

The new system in the UK, which has introduced greater bureaucratic control of the profession, has weakened the ability of those who understand standards and accreditation of the profession best to be involved in driving through appropriate and needed reforms. Advice received from the UK suggests that there is increasing acknowledgement that the profession is now constrained in introducing improvements that are recognised as being required.

Similarly, in Australia, those who have most effectively built and maintained excellence in standards and accreditation of the medical profession are the members of the profession itself, together more recently with the independent Australian Medical Council (AMC). To reduce the independence of the AMC and / or to reduce the capacity of the profession to drive required reforms would interfere with potential future improvements to medical education and to healthcare standards. The College Presidents believe the COAG national registration and accreditation scheme (NRAS) as proposed would diminish rather than improve the current accreditation and standards setting model. In addition, the registration scheme as proposed seeks to impose additional layers of bureaucracy which will not contribute in any worthwhile way to the objective of improving the safety and quality of healthcare services.

The CPMC's Position on Accreditation of Medical Education and Training provides the following -

'Accreditation should remain independent of registration arrangements, as per the Productivity Commission recommendations. Accreditation should therefore continue to remain independent of legislation for a national registration system.

These features must apply to effect independent accreditation

1. *The role of accrediting medical education and training must be fully delegated to a body with medical professional expertise (the accreditation body).*

2. *The accreditation body must be independent from any outside influence, including from influence or interference in its decisions by any or all levels of government or any government-established body, in undertaking the following activities:*

   - *the setting of standards;*
   - *ongoing accreditation of individual education and training courses; and*
   - *assessment processes for international medical graduates (IMGs).*

3. *In particular, formal arrangements for accreditation must explicitly preclude Ministers or any other body from –*

   - *having any role in the approval of, or issuing directions in respect of, accreditation standards developed by the accreditation body;*
   - *having any role in respect of accrediting individual courses; or*
   - *interfering with the day-to-day operations of the accreditation body.*

4. *The structure and the appointment process of the accreditation body must have professional credibility to maintain the confidence of the community and the profession.*

5. *Formal arrangements for the accreditation activity, including the detail of the governance, accountability and decision-making arrangements, must comply fully with international guidelines for accreditation of medical education and training to ensure that there are no unintended consequences for Australian trained medical practitioners intending to practice overseas or international students intending to study medicine in*

Australia. It must be verified that the Australian accrediting body has international acceptance and recognition.

6. *Formal arrangements should continue to legally recognise the role of Medical Colleges in -*

   - *accreditation and standard setting;*
   - *determining specialist qualifications held by medical practitioners;*
   - *managing CPD programs for the medical profession; and*
   - *assessment of IMGs who are applying for recognition to practise in Australia.'*

Copies of advice submitted previously in the course of the development of the proposed scheme are attached for information. It has to be said that whilst there was much apparent 'consultation' activity over the several years during which the IGA proposal has been developed, it is difficult to accept that that activity was carried out in good faith. In regard to virtually every issue, the profession's advice and views have been ignored as the responsible jurisdictional officers continued jointly to pursue a covert, presumably ideological, agenda.

Terms of Reference
The following comment is offered in regard to specific Terms of Reference.

Clause (b) The impact of the scheme on patient care and safety
Elements of the proposed scheme seek to build on the Productivity Commission recommendation that an advisory health workforce improvement agency be established to evaluate nationally significant workforce innovation opportunities, particularly those which would cross current professional boundaries, with the objective of making better use of available health workforce skills.

The CPMC member Colleges have long recognised the opportunity for and value of other health workers enhancing their roles in such a way as to provide integrated health care in a team approach. There are many instances of such evolution which has occurred over the years and continues to occur in medicine, nursing and allied health roles. There is concern, however, that current initiatives within the proposed scheme appear to be based, to some extent at least, on a confusion of the ability to perform isolated procedural tasks with the need to provide comprehensive diagnostic and therapeutic leadership roles within the healthcare system. It is vital that the primary consideration underpinning any further evolution of health workforce roles is the maintenance of patient safety and the quality of patient care, rather than 'quick fixes' designed to ease jurisdiction workforce shortages.

In addition, the scheme continues to provide for the use of an endorsement on the general register to denote a medical specialist (which includes general practitioners) rather than the establishment of a separate register of specialists.

The real issue is to protect patient safety and promote public confidence in the system by ensuring that the specialist assessment and specialist recognition processes are sound. Cases presently before Australian courts, which are alleged to involve the death and mutilation of patients, will not be prevented by the arrangements proposed. A major underlying concern in both cases rests not with the validity of the specialist assessment process but the departure from agreed processes by jurisdiction health administrations.

The specialist endorsement arrangement as proposed is likely to continue to allow a generally registered medical practitioner (or the practitioner's administrative masters) to decide his or her own scope of practice, which is totally unacceptable and a serious threat to patient safety. CPMC supports the maintenance of a form of separate register for specialists, as is the current practice in at least four jurisdictions.

It is vital that the new registration arrangements ensure that independent specialist medical practice is undertaken only by practitioners who have specialist qualifications which are accredited by the AMC or whose training and experience have been assessed under the AMC process as substantially comparable to that of an Australian specialist and who are working under 'oversight' for a limited period prior to being invited to apply for Fellowship of the relevant specialist Medical College. All other doctors, including those presently variously recognised by some jurisdictions as 'Area of Need Specialist', 'Limited Specialist', 'Deemed Specialist', etc should be working under supervision. They are not entitled to use the title 'Specialist' and their names should appear only on the general register.

Clause (d) The effect of the scheme on standards of training and qualification of relevant health professionals

The presence of an effective and professional system of accreditation, which is independent of government, medical schools, Medical Colleges and the profession, is essential to ensure the maintenance of the existing high standards of medical education and practice in Australia. The AMC is the current accreditation authority for the medical profession. The AMC has developed and administered practitioner assessment processes and accreditation programs for medical schools and Medical Colleges over many years. The Council has served the Australian community well and its expertise and professional performance is recognised internationally. In addition, the AMC is playing a major role in providing guidance and expertise to Asia / Pacific nations whose medical accreditation arrangements / requirements are at an earlier stage of evolution.

The medical profession would reject any measure introduced into the proposed national accreditation arrangements which would lead to any reduction in the AMC's autonomy, independence or effectiveness.

The need for the legislation to be sufficiently flexible in its terms to cover the diverse range of health professions encompassed by the NRAS proposals is recognised. However, measures which would lead to a reduction in the quality of existing medical profession accreditation standards and processes, in an endeavour to reduce the demands placed on other health professions which do not presently have a significant number of practitioners or high quality accreditation systems, would not be countenanced. CPMC believes that the role of the AMC and the Medical Colleges in regard to standards should be recognised and defined in the legislation.

Clause (f) Alternative models for implementation of the scheme

The CPMC continues to oppose the melding of the registration and accreditation functions in the manner proposed and is of the view that further action in regard to accreditation should be deferred, at least until the proposed new registration arrangements have been implemented effectively. There is ample practical justification for the adoption of the staged approach proposed.

The task of developing a single registration database and recording system for the ten professions involved is a major logistical exercise, far more complex it is suggested than is understood by those charged with developing and implementing the single, national recording

and other systems required. The cleansing and melding of the data (involving 350,000 nursing registrations and 50,000 medical practitioners alone) presently contained on .ten separate registration databases within each of eight jurisdictions will be a serious challenge.

In the interests of ensuring the maintenance of the safety and quality of medical services across Australia, the Presidents of Australia's Specialist Medical Colleges and the medical profession generally urges in the strongest possible terms that the real value of the inclusion of the accreditation function as part of this initiative be reviewed and a final decision to proceed not be made until the registration element of the initiative has been implemented successfully and is operating effectively.

Conclusion

As indicated in the introduction to this submission, the CPMC member Medical Colleges are responsible for the determination and maintenance of medical standards in Australia and New Zealand and for the training and education of medical practitioners across all recognised medical specialties. Accordingly, the principal focus of the Colleges is the quality, safety and standards of medical practice and postgraduate medical training and education in Australia. Through their professional activities, the Medical Colleges represent some 97% of Australia's medical specialists, including general practitioners. As such, I strongly request that the CPMC be afforded the opportunity to appear before the Committee to give evidence at a public hearing in respect of the matters canvassed above or any other relevant issue which would assist the members of the Committee.

Russell W Stitz

Professor Russell W Stitz AM RFD
Chairman

28 April 2009

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REGISTRATION ARRANGEMENTS SUBMISSION

The following comments are provided, on behalf of the Presidents of the CPMC member Colleges, in respect to the matters contained in the Consultation Paper 'Proposed Registration Arrangements' which was issued on 19 September.

Clause 4.3 Criminal History Checks
Option 3 is favoured as the most practical and effective of the options.

Clause 5 Qualifications for Registration
Proposal 5.1. The paper proposes that the legislation define the qualifications for general registration to mean

'**one** or a combination of the following:

- an approved course of study
- an approved period of supervised practice ...and
- an examination (if any)...'.

Certainly, insofar as the medical profession is concerned, a period of supervised practice of itself would not and could not be an acceptable qualification for general registration and inclusion of such a provision in the proposal Bill would be opposed strongly.

Proposal 5.2: It is assumed and it is important that the existing arrangements, whereby the National Board would seek the advice of the relevant specialist Medical College in regard to 'substantially equivalent' training and experience, will be retained. (It might be noted that 'substantially **comparable**' is the current and agreed terminology.)

Clause 6.2 Who makes registration decisions?
Proposal 6.2.1: The CPMC strongly opposes the provision that the chair of a committee exercising registration decisions on behalf of the National Medical Board could be a person who is not medically qualified. In addition, the committee must comprise at least 50% medical practitioners (consistent with the National Board composition).

Clause 9.2 Continuing competence requirements
These new provisions are supported generally. However, as discussed recently, references to 'competence' instead of 'continuing professional development' (CPD) unnecessarily complicate the issue and will undoubtedly lead to serious misunderstandings. Dr Morauta's recent oral advice that this proposal would be revised to eliminate references to 'competence' has been noted.

It would be known generally that the specialist Medical Colleges already have CPD systems in place and expect to continue to have a key role in delivery of CPD relevant to specialist medical practice.

Clause 9.3 Annual reporting obligations on registrants
Proposal 9.3.1 (and 9.4.3): It is considered that some of these proposed provisions are unduly onerous and are unacceptable in their present form. The requirement to report untested medical negligence claims and criminal charges requires further explanation and review, particularly in regard to natural justice implications. The incident of a claim of medical negligence should not require notification. The processing and outcome of claims is complex and, if notified at all, should not be before finalisation resulting in an adverse finding.

Proposal 9.3.1(e). The unqualified provision requiring the **compulsory** reporting of 'any data' for 'workforce planning purposes' is far too broad and is unacceptable in the form presented.

Clause 10.1 Specialist endorsement
Proposal 10.1.1 This organisation has responded previously about the importance of the relevant National Board(s) being made aware of proposals submitted by other Boards or the Advisory Council in regard to issues which have the potential to impact on scopes of practice and other professional matters. It is vital that the Ministerial Council is not asked to make a decision on any matter without having the advice of all relevant Boards.

Clause 11.3 Failure to renew
Proposal 11.3.1: The 3 month period of grace is supported.

Clause 11.4 Reinstatement to the Register
Proposal 11.4.1: The proposal for restoration to the register within a period of two-years is supported.

Protection from personal liability
This issue is not raised in the consultation paper. However, it is noted that Clause 54 of Bill A provides protection from personal liability for -
(a) a member of the Agency Management Committee;
(b) a member of a National Board or a committee of a National Board; and
(c) a member of staff of the National Agency.

During discussions leading to the development of the National Scheme, undertakings were received that Medical Colleges and College Fellows / staff engaged in assessing the qualifications of international medical graduates on behalf of a National Board or a committee of a National Board would be indemnified against any action arising from that activity. It is important that this issue not be overlooked when further legislation or regulations are being developed.

Les Apolony
Chief Executive Officer

30 October 2008

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ACCREDITATION ARRANGEMENTS SUBMISSION

The following comments are provided, on behalf of the Presidents of the CPMC member Colleges, in respect to the matters contained in the Consultation Paper 'Proposed Arrangements for Accreditation' which was issued on 6 November.

The CPMC Position on Accreditation

The CPMC has long supported the concept of a national registration scheme for medical practitioners which would -

- ensure that patient safety and the quality of patient care provided to all Australians is not reduced or compromised in any way;
- facilitate the ready movement of registered practitioners across Australian jurisdictional boundaries;
- be supported by nationally uniform policies and regulatory guidelines and not rely on mutual recognition of jurisdiction-based registration; and
- protect against unilateral departures from uniformity over time by individual jurisdictions as political responses to subsequent events within those jurisdictions.

At the same time, the CPMC has expressed its concern regularly that the authors of the Intergovernmental Agreement (IGA), during the development of that document, ignored the clearly expressed view of the Productivity Commission that the registration and accreditation functions for the health professions should have separate governance arrangements and paid no regard at all to similar advice tendered by representatives of the professions involved. At no time during this COAG process have the IGA authors provided any cogent or compelling explanation of their determination to combine the functions of registration and accreditation, which are separate and distinct in their objectives and purposes.

The only response given is that combining the management of the two functions would be more cost effective. This is highly debatable if the current AMC model were to be retained. There is a growing belief within the medical profession that the real reason is ideological and, more worrying, a quest for additional government control of accreditation processes and standards.

The new system in the UK, which has introduced greater bureaucratic control of the profession, has weakened the ability of those who understand standards and accreditation of the profession best to be involved in driving through appropriate and needed reforms. Advice received from the UK suggests that there is increasing acknowledgement that the profession is now constrained in introducing improvements that are recognised as being required.

Similarly, in Australia, those who have most effectively built and maintained excellence in standards and accreditation of the medical profession are the members of the profession itself, together more recently with the independent Australian Medical Council (AMC). To reduce the independence of the AMC and / or to reduce the capacity of the profession to drive required reforms would interfere with potential future improvements to medical education and to healthcare standards. The College Presidents believe the NRAS proposal would diminish rather than improve the current accreditation and standards setting model.

The CPMC continues to oppose the melding of the registration and accreditation functions in the manner proposed and is of the view that further action in regard to accreditation should be deferred, at least until the proposed new registration arrangements have been implemented effectively.

The Consultation Paper

The presence of an effective and professional system of accreditation, which is independent of government, medical schools, Medical Colleges and the profession, is essential to ensure the maintenance of the existing high standards of medical education and practice in Australia. The AMC is the current accreditation authority for the medical profession. The AMC has developed and administered practitioner assessment processes and accreditation programs for medical schools and Medical Colleges over many years. The Council has served the Australian community well and its expertise and professional performance is recognised internationally. In addition, the AMC is playing a major role in providing guidance and expertise to Asia / Pacific nations whose medical accreditation arrangements / requirements are at an earlier stage of evolution.

The medical profession would reject any measure introduced into the proposed national accreditation arrangements which would lead to any reduction in the AMC's autonomy, independence or effectiveness.

The need for the consultation paper to be sufficiently flexible in its terms to cover the diverse range of health professions encompassed by the NRAS proposals and the consequent lack of clarity and specificity is recognised. However, measures which would lead to a reduction in the quality of existing medical profession accreditation standards and processes, in an endeavour to reduce the demands placed on other health professions which do not presently have a significant number of practitioners or high quality accreditation systems, would not be countenanced. CPMC believes that the role of the AMC and the Medical Colleges in regard to standards should be recognised and defined in the legislation.

1.4 The Intergovernmental Agreement

Clause 1.39 It is noted that the composition proposed for an 'accreditation committee' will not bind an existing body appointed by a national board to perform accreditation functions on its behalf. The AMC has long had explicit guidelines for ensuring broad and appropriate membership of both the Council itself and accreditation panels formed to undertake specific assessments.

3.1 Key features of proposed system

It is noted that national boards will have the power to delegate approval of courses to accreditation bodies.

3.4 Scope of accreditation

Subclause (a) provides for the endorsement or notation of specialist qualifications on an integrated register. The CPMC member Colleges do not consider that this proposed arrangement is acceptable or adequate. There are two principal elements to this issue. One is proper protection of the title 'specialist', in the interest of quality and safety and the other is the availability of reliable, easily understood information to the community.

CPMC supports the maintenance of a form of separate register for specialists, as is the current practice in at least four jurisdictions. A carefully maintained specialist register would assist in ensuring that independent medical practice is undertaken only by practitioners who have specialist qualifications which are accredited by the AMC or whose training and experience have been assessed under the AMC process as substantially comparable to that of an Australian specialist and who are working under 'oversight' for a limited period prior to being invited to apply for Fellowship of the relevant specialist Medical College.

All other doctors, including those presently variously recognised by some jurisdictions as 'Area of Need Specialist', 'Limited Specialist', 'Deemed Specialist', etc should be working under supervision. They are not entitled to use the title 'Specialist' and their names should appear only on the general register.

Subclause (d) provides for 'recognition of new specialties or specialty areas of practice on professional registers to be subject to the approval of the Ministerial Council.' The importance of other relevant health profession national boards being made aware of any proposal which involves the extension of a scope of practice, before Ministers consider such a recommendation, has been raised previously.

Proposal 3.4.2

This proposal is supported.

Proposal 3.4.3

Other relevant national boards must be made aware in advance of any recommendation submitted to the Ministerial Council for recognition of new specialties or specialty areas of practice.

Proposal 3.4.4

The core functions listed are considered to be appropriate.

Proposal 3.4.5

This proposal is appropriate.

Proposal 3.4.6

It is essential that other relevant national boards are made aware of any recommendation for changes or expansion of the range of courses **before** the Ministerial Council is asked to consider any such recommendation.

Proposal 3.4.7

This is a sensible provision.

Proposal 3.5.3 and 3.5.4

These measures are considered appropriate.

Proposal 3.5.5
This provision is supported.

Proposal 3.5.6
This wide consultation must include any other national board which may have a relevant interest.

Proposal 3.7.1
The concept of merit or process reviews exists within the AMC presently. The paper does not give any indication of how costly or complex (for both parties) an external review might be.

Proposal 3.8.1
Extension of the indemnity arrangements as proposed is supported. It accordance with undertakings given previously, it will be necessary for the extended indemnification to cover also College members and staff engaged in the assessment of international medical graduates.

3.10 Accreditation processes
It is pleasing that it is intended to give due regard to both the WFME *Guidelines for Basic Medical Education* and the Professions Australia *Standards for Professional Accreditation Processes* in the development of the legislation and related arrangements. It is essential that the provisions and intention of both publications are observed.

In the sixth paragraph of this section the following appears:
'Membership of accreditation panels should not over-represent the interests of the profession.' This serious lack of understanding requires to be addressed promptly. Medical professionals who participate in AMC accreditation panels are selected because of their specific professional knowledge and expertise. In so participating, they represent the AMC and through that body the interests of the community at large.

Proposal 3.10.1
It is important that the matters detailed are observed closely during the development of standards for accreditation processes.

Proposal 3.10.2
It is appropriate for education providers to be required to notify the relevant accreditation body in the circumstances proposed. However, it is considered it would be more effective to leave the decision as to whether it is necessary for the relevant national board to be advised to the discretion of the accreditation authority, having regard to the particular circumstances and the likelihood of the national board being required subsequently to take any action in regard to the matter. In many cases, it will be possible for the issues to be resolved satisfactorily by the accreditation body.

Proposal 5.1
This proposal is supported.

Proposal 6.1
The transitional arrangements proposed are appropriate generally. However, whilst the general principle about a minimum lead time in subclause (d) is sound, there may be circumstances in

which it would be preferable for a new or revised standard to come into effect without such an extensive delay and in which a lesser period of notice would not create difficulties for course providers or participants. It would be desirable to provide for a lesser period of notice where desirable / appropriate.

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Chairperson

16 December 2008

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PROPOSED REGISTRATION ARRANGEMENTS FOR SPECIALISTS

The following comments are provided, on behalf of the Presidents of the CPMC member Colleges, in respect to the matters contained in the Further Consultation Paper on Proposed Registration Arrangements for Specialists which was issued on 21 January.

The CPMC has long supported the concept of a national registration scheme for medical practitioners which would

- ensure that patient safety and the quality of patient care provided to all Australians is not reduced or compromised in any way;
- facilitate the ready movement of registered practitioners across Australian jurisdictional boundaries;
- be supported by nationally uniform policies and regulatory guidelines and not rely on mutual recognition of jurisdiction-based registration; and
- protect against unilateral departures from uniformity over time by individual jurisdictions as political responses to subsequent events within those jurisdictions.

There are several matters in this further consultation paper which continue to concern the medical profession.

Specialist endorsement

The paper continues to provide for the use of an endorsement on the general register to denote a medical specialist (which includes general practitioners) rather than the establishment of a separate register of specialists. It is understood that at least half of the Australian jurisdictions currently have specialist registers and the CPMC continues to prefer that model.

The real issue is to protect patient safety and promote public confidence in the system by ensuring that the specialist assessment and specialist recognition processes are sound. Cases presently before Australian courts, which are alleged to involve the death and mutilation of patients, will not be prevented by the arrangements proposed. A major underlying concern in both cases rests not with the validity of the specialist assessment process but the departure from agreed processes by jurisdiction health administrations.

It is vital that the new registration arrangements ensure that independent specialist medical practice is undertaken only by practitioners who have specialist qualifications which are accredited by the AMC or whose training and experience have been assessed under the AMC process as substantially comparable to that of an Australian specialist and who are working under 'oversight' for a limited period prior to being invited to apply for Fellowship of the relevant specialist Medical College. The specialist endorsement arrangement as proposed is likely to continue to allow a generally registered medical practitioner (or the practitioner's

administrative masters) to decide his or her own scope of practice, which is totally unacceptable and a serious threat to patient safety.

The need for the proposed legislation to be generic in its approach, so as to cater for the range of professions proposed to be encompassed by it, is acknowledged. However, the CPMC considers that the long-established and vital role of the specialist Medical Colleges in the specialist assessment process should be recognised in the legislation.

Continuing competence requirements
The document continues the use of the term 'continuing competence' when referring to 'professional development'. It was understood previously that this misunderstanding would be corrected in subsequent documents. Notwithstanding the ongoing College initiatives aimed at developing processes which ensure maintenance of competence, it would be misleading and dishonest for the new scheme to seek to represent to the Australian community that participation in professional development programs is reliable evidence of a medical practitioner's competence. There are methods of measuring competence but they vary significantly from professional development programs and tend to be quite resource demanding.

Registration of specialists
The Medical Colleges and the profession generally would be seriously concerned if this proposed new measure compelling Boards to consider applications for area of need registration submitted by applicants who are not eligible for registration in any other category could be used as a workforce measure with a consequent diminution in standards of safety and quality. It is essential that the responsibility of a Board to determine all applications for registration on the basis of the relevant standards not be able to be impinged upon by any outside body or irrelevant influence.

In addition, it is important that the new system protects the title of 'specialist' from use by practitioners who have been registered to work in an area of need position under oversight on the basis of the job description for that specific position. This is a serious problem presently and it is essential that the sanctions proposed under the new system be applied to such practitioners who represent themselves to be appropriately qualified 'specialists'.

Whilst the serious health workforce issues facing the country need to be addressed by urgent and innovative measures, the medical profession will not accept any initiative which impacts adversely on the country's existing medical standards and the quality of health care.

Scope of practice.
It is acknowledged that the CPMC proposal in regard to this issue has been adopted generally. However, the paper provides that a Board 'should' be required to consult other relevant Boards in these circumstances. This is not strong enough. It is essential that the obligation to consult be expressed as 'must'

Accreditation
The CPMC continues to oppose the melding of the registration and accreditation functions in the manner proposed and is of the view that further action in regard to accreditation should be deferred, at least until the proposed new registration arrangements have been implemented effectively. There is ample practical justification for the adoption of the staged approach proposed.

The task of developing a single registration database and recording system for the nine professions involved is a major logistical exercise, far more complex I would suggest than is understood by those charged with developing and implementing the single, national recording and other systems required. The cleansing and melding of the data (involving 350,000 nursing registrations and 50,000 medical practitioners alone) presently contained on nine separate registration databases within each of eight jurisdictions will be a serious challenge.

In the interests of ensuring the maintenance of the safety and quality of medical services across Australia, the Presidents of Australia's Specialist Medical Colleges and the medical profession generally urges in the strongest possible terms that the real value of the inclusion of the accreditation function as part of this initiative be reviewed and a final decision to proceed not be made until the registration element of the initiative has been implemented successfully and is operating effectively.

Professor Russell W Stitz AM, RFD
Chairman

13 February 2009