Review of the Standards for Specialist Medical Programs: Consultation on scope and direction for change

Part 2 - Response template

Your feedback

We would like to hear your perspectives on the proposed scope of the review. We will consider all the feedback we receive when shaping our proposals for change.

We are seeking feedback by **20 June 2025 (extension agreed to 4 July 2025)**.

Please provide your response, by email, as a **word document** or non-protected PDF document using this template to standardsreview@amc.org.au.

This template

This template provides questions related to major themes arising in the standards review. This template should be read in conjunction with the **Part 1 - Consultation on scope and direction for change**, which outlines the background and review process, along with the major drivers shaping the review.

We recognise that not all questions (either in whole or in part) below will apply to all stakeholders, please only respond to those that are of relevance to you. There are spaces for general comments.

Your information

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I consent to my response being published on the AMC's website	Yes

Consultation questions

The themes discussed in the consultation paper cover the entirety of the standards, each theme fits into one or both of the key aims of the review:

1. Education and training programs responsive to community needs
2. Promoting/protecting high quality training that supports trainee and supervisor wellbeing

Questions relating to the standards for specialist medical programs
1. College inclusion of varied perspectives, experiences and expertise 1A. What are the potential barriers for colleges to provide evidence to demonstrate who has a meaningful voice in governance and decision-making e.g. meaningful trainee representation?
Attendance at meetings is a marker and there may potentially be no barriers to proving evidence through providing documentation of governance structures to demonstrate transparency and inclusive decision-making. However, the key barrier will be addressing what is expected of, and meant by, the AMC as evidence of "meaningful voice". This is in the eye of the participant. Trainee representation on committees and during consultation is invited but requires a time commitment which may discourage many trainees. Trainees may lack perspective on independent practice and are understandably consumed with the immediate realities of the training program. Trainees may not be in the best position to co-design their training program due to limited experience of the requirements of the work, and not fully understanding the standard required for expert practice. The challenges that exist are in equipping trainee representatives to be able to participate meaningfully and in measuring their influence beyond just attendance and to measure and provide evidence of normal committee activities. This is often due to the short tenures and turnover of trainee committee members and the unclear scope of their roles. This shouldn't be any reason not to seek co-design of approaches to learning, but expectations would need to be managed. There is also concern about how this metric will be measured - representation doesn't equal contribution and contribution doesn't necessarily equate to value. It would be possible to demonstrate innovation and improvement activities through committee activities.
1B. How could the standards increase emphasis on the contribution of Aboriginal and/or Torres Strait Islander and Māori people and consumers as experts in their experiences?
These voices should shape both education and cultural safety frameworks, with First Nations and Māori people guiding ongoing reflective practice within the college and the development of learning and assessment. The standards could be strengthened through the requirement of providing evidence of these people (including context specific consumer groups to ensure meaningful input) being involved in the co-design and delivery process, with guidance on things to be considered during the consultation. This may include the benefits of decisions made by the college on, say, education, assessment, governance, research, advocacy on health equity; the potential implications for these populations of new proposals – this requires more than self-reflection by ANZCA, only First Nations people can know what the implications are for them. Timelines would need to be more flexible if a co-design approach is used. Some co-design methodologies eschew timelines altogether. The consideration of cultural loading on fellows (who have the best understanding of the combination of speciality training and indigeneity) is critical and ideally this may move into a space where that is shared among the whole community rather than relying on a few individuals. We acknowledge the aspirational purpose behind co-design but feel it is important that AMC acknowledge there are considerable barriers that will need to be overcome (including but not limited to college governance) when setting the standards.

1C. What do you think are the opportunities and challenges for colleges in meeting strengthened standards? What are the expectations and measures that the standards should articulate?

Opportunities:

- A strengthened emphasis presents opportunities to better align specialist training with community needs, particularly for regional and Indigenous health priorities.
- Opportunities in collaboration between colleges, including nursing and allied health, on standards for equity, inclusivity and diversity. There is no benefit in having a raft of different / conflicting standards.

Challenges:

- Implementing changes across binational settings and balancing specialty-specific needs with broad principles.
- Standards should specify expectations for measurable engagement outcomes, curriculum inclusivity, and evidence of workforce alignment whilst having flexibility, especially within the smaller colleges.
- Volunteer fatigue. The recruitment of members with the required skills and values to offer value will be from a very small membership group. The colleges rely on specialists to contribute to design, development and delivery. The increase in work pressures (especially in NSW) have decimated the clinical workforce, let alone the volunteers. We are at a critical juncture where medical practice, including the domains of education and scholarship, risk being sidelined or diminished.
- Separation of the roles and responsibilities of the college as an employer (to its staff, not of trainees and fellows) and the role of the employer. For example, if a midwife bullies a trainee, currently the college has no ability to intervene as this is an employer responsibility with the college having very few levers to effect change.
- The ability of the college to set the standard of safe specialist practice is being eroded by the proposed new standards and the pressure to maintain accreditation of training sites. Workforce pressures mean colleges are under pressure to turn out specialists and support the SIMGs pursuing specialist posts, whether they are assessed by us or not. There is variability in training in Australia and Aotearoa however this is insignificant in comparison to the variability in overseas trained specialists.
- The continuing added regulatory and compliance requirements for colleges is at an all-time high with continuing expectations that are required to be met. This is placing significant pressure on colleges who have limited resources and member-funded budgets.

2. Collaboration across colleges and partnerships to support safety, quality and innovation

2A. Trainees are learning in environments that are providing a healthcare service, which rests on partnerships between service providers and education providers. There is a joint responsibility across these providers for ensuring the quality of learning and the trainee experience. How could the standards support or enhance partnerships between colleges and employers?

The standards should support by encouraging and strengthening partnerships with hospital employers by requiring collaborative supervision frameworks, data sharing, and co-owned trainee wellbeing strategies. This is critical given trainees' reliance on local departments for practical experience and support. In

addition, this may benefit from centralising some processes, so they aren't duplicated unnecessarily across colleges. For example, identification of and support for Aboriginal and Torres Strait Islander organisations to engage with colleges.

Providing a platform and provision for colleges to collaborate on identifying employers who need support to create a supportive environment for training. Bringing in standards to lift the performance of underperforming colleges creates busy work for those who are meeting the standards – it may be appropriate to consider a strategy for benchmarking against colleges who are meeting the requirements. The AMC could support or provide a platform for this collaboration.

2B. A clear theme in the review is the increase in accountability to the communities of Australia and Aotearoa New Zealand. This can be influenced by emphasising meaningful engagement and partnerships with groups such as Aboriginal and/or Torres Strait Islander and Māori community organisations and consumer organisations.

What opportunities do you see in the standards to strengthen relationships between colleges and community groups, at national and localised levels?

ANZCA consults a wide range of stakeholder groups when developing new policy or making changes. The first step would be identifying which community groups would be interested, willing and able to form relationships with colleges. To support the colleges public accountability, the standards should require formalised relationships with First Nations, Māori and consumer organisations through joint governance roles and curriculum partnerships. Other groups worth considering – patient support groups and community health promotion groups. National and regional collaborations will ensure training reflects diverse patient experiences. It is important to consider the value in building these relationships for all parties.

2C. The review has also heard that there is an appetite for increased collaboration across colleges.

What opportunities do you see in the standards to enhance and support greater collaboration and partnership?

This can only benefit. This may include shared frameworks for multidisciplinary team training standards or similar, trainee wellbeing, cultural safety, and innovations in simulation-based assessment. This may include attending shared courses e.g. in trauma, crisis management (including obstetrics), courses for educators, training in cultural safety, workshops on psychological safety (e.g. operating with respect could be adapted for wider group of specialities – surgery, anaesthesia, perhaps ED and ICU with some rebadging). Co-design of mutually shared documents, with guidance from AMC, could be a useful exercise both in building some collaboration and also ensuring consistency of standards. Makes sense for unified standards for professional behaviour, bullying harassment, learning environment, cultural safety, supervision and feedback. The standards should incentivise cross-college partnerships and joint workforce strategies, and community of care learning.

3. Selection into training and retention

3A. There are legal requirements in Australia and Aotearoa New Zealand relating to recruitment processes. What do you think needs to be included within the accreditation standards over and above these legal requirements?

Policy isn't necessarily translated to practice by employers, with the college lacking levers other than removal of accreditation where employers are appointing training places. It's not clear that adding

additional standards or policies will translate to better practice. There is no benefit in making the standards unattainable.

Over and above legal requirements, the standards should require colleges to adopt equitable and appropriate training for recruitment panels, aspirational goals, standards on cultural safety and bias training for those on selection panels, defining success (which is not necessarily numerical/ratio based) and data collection.

3B. The review has heard that there needs to be a balance between doing the right thing by the individuals that are suited to the program, and not setting people up to fail. What indicators could be referenced in the standards to provide quality assurance and accountability that colleges closely monitor selection and ensure compliance with policies?

Quality assurance for ANZCA selection processes could include external audits, and data collection of links to graduate outcomes and meeting workforce needs (broader than tracking of progression from application to Fellowship), and regular review of alignment between selection metrics and training outcomes. Employer responsibility is a big part of the trainee experience that the college has few levers other than accreditation to affect. Noting that additional indicators require systems and staff resources to manage, further placing pressure on colleges.

3C. Selection into training can be managed centrally by the colleges or locally in line with workforce needs and other factors. How can the standards ensure the best principles and appropriate models of selection?

Standards should support ANZCA in using transparent, evidence-based models that balance national workforce distribution with high standards of clinical care and trainee support. This might be a case-by-case basis, with expansion of the standards not necessarily being the correct response. Future proofing for changing workforce needs may be difficult if there is too much emphasis on selection.

Site processes could include:

1. Accredited sites having documented selection policies and procedures that are aligned with ANZCA's overarching principles (which could be audited as part of site accreditation processes).
2. Training sites could be required to demonstrate how they regularly review selection outcomes—for example, through annual reports, debriefs, or comparison of applicant data with selection outcome
3. Monitoring of trainee progression and attrition trends at each site.

3D. There has been discussion about standardised use of data across colleges, including tracking recruitment and progression of diverse cohorts. What do you see as the obstacles for colleges in moving towards annual monitoring of, and reflection on, a standardised data set? What data do you see as valuable in monitoring recruitment, selection and retention?

Obstacles for ANZCA include differing data collection systems across health jurisdictions, insurance companies and other health data sets. Legislation around privacy has been a barrier, with data integrity also being an issue - valuable data include applicant diversity, geographical placement, completion rates, and wellbeing indicators. Other data that may be helpful is graduate data from medical schools based on region. Annual reporting would support continuous improvement.

4. Curriculum content and graduate outcomes

Colleges define what the trainee has to learn in order to become qualified as a consultant in their specialty. There are currently no set graduate outcomes for specialist training in Australia and Aotearoa New Zealand.

4A. The review is exploring what non-specialty-specific outcomes might include e.g. professionalism, cultural safety, quality and safety, digital capability etc. What areas do you consider most important in this context?

All domains that are not specific to the knowledge and skills of the speciality are to a large extent, shared – e.g. professional, collaboration, communication, leadership, advocacy, critical appraisal of the literature, reflective practice, self-directed learning, cultural capability, interprofessional collaboration, digital capability, global citizenship, and systems thinking. Professionalism and patient-centred communication should also be core. Professionalism is key to everything we do, ANZCA has developed a document specifically supporting this - *Supporting Professionalism and Performance: A guide for anaesthetists and pain medicine physicians*. Need to ensure that approaches to this are restorative rather than punitive.

It would make sense to have a common stem and, where necessary, outcomes specific to the speciality.

4B. What do you see as the obstacles and opportunities in developing common outcomes?

There is currently limited structure within our health system that promotes or supports collaboration between disciplines. The AMC could usefully promote such a structure and/or provide some initial leadership. While differences exist across specialties, ANZCA would benefit from common graduate outcomes related to safety, equity, and teamwork. Challenges will be aligning curriculum renewal cycles and avoiding duplication.

The Council of Medical Colleges in NZ could be a starting model, though it lacks teeth.

5. Specialist International Medical Graduates' (SIMGs) experience

Colleges have a role in assessing the comparability of SIMGs to specialists who have completed their education and training in Australia and New Zealand. This role can include providing additional education, training and/or supervision to prepare specialists trained overseas for practice in the Australian and New Zealand healthcare context. Environmental scanning and feedback to the review indicates that colleges' processes need to be more transparent, supportive and quality assured.

5A. How might the standards set expectations to achieve this?

The standards need to note the different roles the colleges' assessments take in relation to the two countries regulators (Medical Board of Australia and Medical Council of New Zealand) and ensure that either there is one standard compatible with both, or separate standards for each country. The overarching standard is that the colleges must comply with relevant legislation and regulatory authority requirements.

Each regulator should also set up a reporting dataset which can monitor compliance with assessment standards (the MBA already has reporting requirements that monitor colleges' processes and adherence to the MBA standard; if not already done so, the reports should be publicly available to ensure transparency).

It should be emphasised that each medical specialty differs significantly from the others and the assessments and upskilling that are part of the SIMG assessment will be specific to that specialty, so the standard needs to allow for that, and for the colleges to be the experts in practice of their specialty.

As at times SIMGs being assessed have had their initial specialist training many years ago and practice of their specialty may have changed considerably in the meantime, the processes that ensure up-to-date

practice such as effective CPD including practice evaluation and recency of practice need to be included in the assessment of comparability.

Any standard has to contain an assurance that at the end of the process, the SIMG is at the same standard as a recently locally trained specialist.

In addition, ANZCA includes the involvement of community representative(s) in SIMG assessment processes to ensure accountability to the public.

5B. What might the standards include so that SIMGs are prepared for culturally safe practice in Australia in relation to Aboriginal and/or Torres Strait Islander and Māori health outcomes?

Many aspects of culturally safe practice are common across all colleges and yet are varied according to the site at which they intend to work. The initial standard should make such preparation compulsory but allow for multiple methods of meeting that standard and include training in dealing with unconscious biases (which is relevant to all cultures, including those related to age and socio-economic status e.g. teenage male subculture which has significant health consequences).

A related issue for SIMGs is learning about the medical culture of Australia and Aotearoa-New Zealand. As an example, our less hierarchical medical culture, in which speaking out is encouraged and patient autonomy is supported, differs from that in countries from which many of our SIMGs have come. This, along with learning about the social culture of our countries would be of great assistance to SIMGs settling into our countries and providing a valuable contribution to our societies.

ANZCA would recommend a separate standard for preparation for safe practice so that the SIMG is prepared for the medical and social cultures in our countries (this is highlighted in a recent publication, which, while focused on New Zealand, is pertinent to practice in Australia as well: Mannes et al. The international medical graduate journey in New Zealand, International Journal of Medical Education. 2023;14:43-54 ISSN: 2042-6372 DOI: 10.5116/ijme.6440.0e37).

6. Trainee support, wellbeing and connection into colleges

On a day-to-day basis, the trainee experience is experienced at a local level. It is created by local individuals and the service provision in the area. There may be a disconnect with 'college central'.

The standards need to reflect where the trainee is learning, provide protection, and highlight where a trainee might go for support, regardless of setting, team or specialty.

6A. What do you consider the most important aspects for trainee support at a local level?

Enthusiastic, committed, well-resourced supervisors of training and supervisors with good interpersonal skills and knowledge of understanding of teaching, learning, feedback and assessment and a willingness to enhance their educational capabilities.

The key aspects include protected mentoring time, regular welfare checks, and peer networks and protected teaching. Colleges should oversee consistent implementation across sites via regional training committees. The barrier that needs to be addressed here is the demand between service and education.

Another key aspect is the training and preparing of supervisors of training and education officers with the knowledge and skills required. Some level of training, probation and regulation might be considered, not just experience or seniority.

Knowing who to go to and that it's safe to go to them – some medical schools have an independent student support person – perhaps someone employed by the college but at a distance, who can be trusted with confidential information.

6B. What do you see as the key obstacles to ensuring the provision of cultural and psychosocial safety of trainees at a local and a college level?

Work pressure, lack of time, limited requirements to become a supervisor of training or supervise trainees, limited opportunities for trainees to provide feedback on their supervisors or supervisors of training (usually only at accreditation visits), variability in site-level support, underreporting of discrimination, and insufficient attention to psychological and cultural safety and trainee welfare.

Standards should mandate transparent and accessible pathways for raising concerns, with guaranteed confidentiality and anonymity. Additionally, all supervisors should be required to undergo training in psychosocial and cultural safety to foster inclusive, supportive learning environments. Equally, trainees need training in aspects of giving and receiving feedback etc to provide them the skills and mindset to deal with work and training. Trainee feedback to supervisors could be done with a supportive, departmental model using trainee feedback to positively build supervisor skills. Colleges could provide appropriate tools for departments to use (or these could be shared between colleges).

7. Assessment

The review has heard that being overly prescriptive about assessment methodology is less desirable than providing colleges the opportunity to rationalise their unique assessment strategy and approach. However, the review has also heard concerns about the burden of assessment, formats of assessment that aren't perceived to be optimal practice and the robustness and fairness in the delivery of assessments.

7A. There is significant variability in college assessment methods, what do you think are key components of assessment to ensure graduate outcomes, patient safety, emphasis on Aboriginal and/or Torres Strait Islander and Māori health, while still ensuring flexibility in assessment approaches between colleges?

Assessment standardisation between colleges is important to ensure fairness, public trust, and workforce mobility across the healthcare system. By aligning on shared principles and outcome benchmarks, standardisation promotes equity in how trainees are evaluated and reassures the public that all clinicians meet a consistent threshold of competence. It also facilitates the portability of qualifications and enables quality assurance across institutions. However, flexibility must be preserved to accommodate the unique competencies of each specialty, support cultural and contextual relevant assessment practices, and encourage innovation. A balanced approach where assessment is anchored within a national framework but allows contextual adaptation will ensure assessments maintain both consistency and relevance in medical education and training. This impact will be achieved by colleges moving to a national programmatic framework with standardised progression assessments, leaving flexibility within college training to use assessments to inform training and learning.

The key will be to move to a capability framework that is underpinned by high level competencies and capability-based assessment at the progression points (e.g. part one and finals). As healthcare systems face increasing complexity in both disease patterns and service delivery, there is a growing need to adopt a capabilities assessment framework within a programmatic approach. This shift enables the systematic training and upskilling of clinicians, ensuring they are equipped with the adaptive competencies required to manage evolving clinical challenges and deliver high-quality, person-centred care.

The curriculum for these domains of practice comprises knowledge, skills, and attitudes/behaviours. Core knowledge, e.g. on health equities, health effects of colonisation, patient safety can be assessed in written exams. Participating in interactive workshops, explicit inclusion of cultural safety in workplace-based assessments, perhaps using self-reflective tools to promote critical consciousness. Specifically incorporating issues relevant to culturally safe practice into assessments such as observed patient interactions. It would

be helpful to have an agreed curriculum which could be across specialities, provide guidance on options, and then allow flexibility on approach on how the desired outcome of the curriculum would be achieved.

7B. How might the standards require evidence of strategies to identify and support changing and diverse cohorts in considering the assessment program?

Standards should require colleges to monitor assessment outcomes across diverse groups and implement data driven changes to support equity and appropriateness.

It would be helpful if AMC provided some guidance – the lack of direction from AMC on where assessment should be going leaves colleges second guessing. If the AMC supports a move towards outcomes-based programmatic assessment incorporating a range of assessment tools, and integrated across the continuum of learning it could helpfully articulate that so colleges would be more likely to move in the same direction.

7C. How are colleges managing and/or incorporating changes in assessment methodology, e.g. OSCEs, programmatic assessment, impact of AI, while ensuring a robust, consistent and fair assessment to produce competent and independent medical practitioners?

At ANZCA, we are building a college wide assessment framework, assessment blueprint and mapping of the assessment landscape that is supported by a trainee lifecycle that underpins all changes and adjustments with data and supported by a strong and robust governance and appeal process(es).

This framework will also be flexible and dynamic enough to support changes in learning and assessment that enable the incorporation of new and emerging technologies, such as AI, in a responsive, sustainable, and measured manner.

In saying that clarity about AMC expectations could help colleges manage change. If AMC stated that the goal was programmatic assessment with a comprehensive system of assessments incorporating both knowledge and performance in the workplace then colleges would know what sort of changes they needed to make, if any, and that would be a useful starting point. Likewise, there are recognised approaches to evaluating the quality of assessments – it could be helpful for AMC to facilitate collaborative workshops to develop common approaches to evaluation of assessment quality.

8. Training model reliant on supervisors

To be responsive to community health needs, collective outcomes across colleges need to contribute to the development of a sustainable workforce model, in particular in regional, rural and remote areas. Traditionally, education of a future consultant has been provided by those with Fellowship in that specialty area. Stakeholder feedback to the review has highlighted the risk of the reliance on that model given the pressures of clinical provision in a complex system under pressure.

8A. Who else could be involved in the training and support of trainees, or what additional models should be considered?

We need to ensure high quality training, and thus high-quality supervision. Some aspects of practice are generic but when it comes to anaesthesia care for a critically ill patient, anaesthesia expertise is required. It's possible there may be scope for distant supervision of senior trainees who have highly developed procedural skills but may need support in decision-making. Advancing technology may help here e.g. a virtually present consultant.

Standards supporting team-based education and community of care models relating to recovery nurses, other specialist with appropriate levels of anaesthetic skills, perioperative physicians, and simulation educators, may be relevant. In the context of pain medicine, this may involve collaborative training

environments across disciplines (e.g. psychology, rehabilitation, general practice) while ensuring oversight by a specialist pain medicine physician to maintain fidelity to the training standards and complexity of care required.

8B. What do you consider some opportunities and/or challenges of a model of interprofessional supervision, given that trainees work in multidisciplinary teams?

This would work for many skills e.g. leadership, teamwork, professionalism, cultural safety and should promote collaborative practice. Interprofessional supervision may offer learning on teamwork and patient flow, however it won't work for discipline specific expertise due to patient safety risks.
It's appropriate to seek feedback from other professions but it is not appropriate for other professions to supervise our trainees. There is a lack of interprofessional knowledge for some specialities where exposure is limited or non-existent at the graduate level and some prevocational doctors. Every intern does a general medicine, surgery and ED component however Fellow of the Royal Australasian College of Physicians (FRACPs) often have very limited in-theatre experience, and absolutely no critical care experience in many cases. This makes it entirely inappropriate for doctors from other specialities to supervise our trainees. The time critical nature of much of our work means that supervision standards must be maintained to protect patient safety.

8C. How might the standards strengthen support for supervisors and therefore the experience of trainees within the current model? E.g. supervisor professional support/development, greater opportunities for feedback, recognition of prior training undertaken for other stages of the medical education continuum.

Regulatory requirements for increased time allocation for supervisors of training plus allowances for extra time 'teaching lists' and standards for time allocated to feedback to trainee after a day working with a supervisor. Something that drives employers and departments to allocate time and FTE to supervision as the major influence on this is the employer. As a supervisor, one underperforming trainee will consume a huge amount of time and energy. The long-term payoffs are worth it for the community; however the employer frequently doesn't recognise the value. The employer is government funded, usually providing minimal or no incentive to support doctors engaging with this process. The value to the employer is in delivery of clinical care which ignores a significant skill set and expertise. Mandating engagement with college processes and accreditation and being able to use those towards reflective practice CPD, would increase representation and make it easier to justify to employers.

Standards could also require colleges to offer structured supervisor development, including cultural safety and feedback training, bias training as well as recognition of prior educator supervisor experience.

9. Addressing issues at training sites

A key piece of work influencing the revision of the standards is the Health Ministers' Policy Directive and the implementation of the recommendations made by the National Health Practitioners Ombudsman (NHPO) related to college accreditation of training sites. The standards for specialist medical programs will require the implementation of the model standards developed as part of the Ombudsman's work. Part of this work also includes the development of a Framework for managing concerns and complaints about accredited specialist medical training settings.

9A. What do you see as barriers and enablers to ensuring trainees can safely report issues at a training site including issues regarding racism?

Enablers include cultural safety training, a culture of zero tolerance to racism, anonymous reporting tools - independent and confidential pathway for trainees to discuss/report issues, an established program of support for First Nations trainees providing a safe and supportive space, third-party reviews, cultural safety audits, and learning support and mentoring (could potentially be inter-disciplinary e.g. in University of Auckland there is a MAPAS program that has regular events, forums for discussion, spaces to support Māori and Pacific medical students).

Barriers include lack of trust, fear of repercussions or reputational damage, risk to continuing goodwill of clinicians to supervise, power hierarchies, and lack of anonymity (particularly when training in a small team).

Standards should mandate centrally coordinated, college-level reporting systems that provide anonymous, independent, culturally safe, and responsive channels for reporting.

Questions relating to the model and cycle of AMC accreditation for specialist medical programs

10. AMC accreditation cycle and process

The review is considering a re-balancing of AMC accreditation and monitoring processes taking account of the complex environment, while being mindful of costs. The AMC is reviewing the current 10-year accreditation cycle to determine if a more frequent, less intensive process would be more efficient. One option for consideration is a shorter cycle e.g. 5 years, with targeted reviews focusing on critical standards and community needs.

10A. What do you see as the potential benefits and drawbacks of a thematic approach to accreditation and monitoring, where each year focuses on a specific core area for all colleges, such as assessment, Aboriginal and/or Torres Strait Islander and Māori health, cultural safety, curriculum development etc.?

A thematic approach to accreditation and monitoring, where each year focuses on a specific core area across all colleges, offers several potential benefits. It allows for deeper, more focused exploration of critical domains. This can drive sector-wide improvement, foster shared learning, and ensure that emerging priorities receive sustained attention. It also supports a more agile and responsive accreditation model, aligning with the evolving needs of communities and the healthcare system.

However, a thematic approach may risk overlooking interdependencies between standards if not carefully integrated into a broader quality assurance framework. It could also lead to variability in preparedness among colleges, depending on their internal cycles and resourcing. Additionally, without careful planning, the approach might inadvertently increase administrative burden or create misalignment with other regulatory or institutional review processes.

This approach may not work based on the complex and interdependent issues in our training program and health system. The burden of the AMC assessment is however exhausting, takes away from innovation and can encourage ticking the boxes rather than fundamental change. Ideally colleges aren't responding to a huge amount of work at every accreditation if broad metrics (trainee engagement, SIMG approval, CPD operations etc.) are in line. Short to long term goals are appropriate and there is value in external scrutiny, however it would be concerning if frequent accreditation would over time mean that we needed to respond to 10 years of curriculum review in a much shorter timeframe. There is a natural lead time on all interventions, and items such as co-design do not lend themselves to timeframes. Really implementing change takes time so consideration must be given to the process and resourcing present in colleges.

It's also not clear how much autonomy the colleges have in responding particularly in a fluctuating environment. It is not clear how the conditions should be implemented (around supervision for example) given the changes in that space. At times significant work goes towards a response which is then superseded by government changes.

Overall, a thematic model could enhance relevance and responsiveness in accreditation, provided it is implemented with flexibility, clear communication, and strong alignment with overarching standards and goals. More commonality of standards across colleges, less focus on the detail and more on achieving high level themes could reduce the burden and perhaps generate a shorter list of recommendations. Colleges often need many years to address each of these detailed recommendations – could be hard in a shorter time, unless there were fewer of them.

10B. What do you think the AMC can do to develop effective relationships with colleges and other stakeholders in the space?

The AMC could consider adopting a structured *stakeholder engagement strategy* and collaborative spaces focused on transparency, co-design, and cultural safety to enhance trust, collaboration, shared accountability, and resources across colleges and the accreditation ecosystem.

Engagement with CPMC would also be effective.

Accreditation visits with more opportunities to meet with clinician stakeholders – one of ANZCA's most recent version had two opportunities which were hard for people to attend. There is no onus nor responsibility for the employer to release a clinician to meet with the AMC. Most fellows are volunteers, using their own time to engage with accreditation.

Key actions may include:

1. Establishing regular, structured engagement forums with colleges and key stakeholders to facilitate open dialogue, share updates, and collaboratively address emerging challenges.
2. Embedding co-design principles in the development and review of accreditation standards and processes, ensuring diverse stakeholder voices are meaningfully included from the outset.
3. Prioritising culturally safe engagement, particularly with Aboriginal and Torres Strait Islander and Māori communities, to build respectful, inclusive, and responsive relationships.
4. Providing tailored support and capacity-building resources to assist colleges in meeting evolving standards and fostering continuous improvement.
5. Maintaining a balance between regulatory independence and partnership, ensuring that the AMC's oversight role is exercised with empathy, transparency, and responsiveness.

Overall

11. Any other comments

11A. From your perspective, in your role or at your organisation, is there anything not covered in Part 1 – Consultation paper or in the consultation questions that you think needs to be a focus for the direction of changes to be made to the standards? Are there any additional opportunities you don't think have been identified?

Very supportive of increased collaboration, common standards and shared resources between medical specialist colleges, and also nursing and allied health.

Cultural safety and addressing health inequities is essential. There are very few First Nations anaesthetic or pain medicine fellows or trainees and we must avoid cultural loading. AMC needs to recognise this and could usefully provide support to colleges in this mission through fostering collaborations or building relationships with First Nations people which could include the colleges.

The increase in governance requirements presents a financial challenge for colleges. Currently the colleges are wearing the fall out of changes to CPD and increased pressures on a system that isn't set up for equitable practice. The regional workforce problem in anaesthesia might be largely solved by GP anaesthetists only receiving a provider number which allows for Medicare billing of anaesthesia services in MMM3-7 areas, however that isn't under the domain of ANZCA. There are no methods of selecting or training doctors to work regionally that are sufficiently efficacious - government levers must be employed, however if the colleges are to take responsibility for implementing these that will add additional cost that must be borne by members (trainees are the obvious scapegoats) which is anathema to trainee wellbeing.

AMC could provide more clarity in what it considers the model of best practice, potentially developing this in collaboration with colleges. While this will always be evolving, explicitly promoting a model of best practice and bringing colleges along with this model could be a way of promoting more alignment and less variability.