Unaccredited, Underutilised, or Unaccounted For?

Is it fair for junior doctors to be disproportionately burdened with service provision with no guarantee of obtaining a surgical training position in the future?

Elizabeth Coady

Sydney Medical School
The University of Sydney

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Introduction

For the most hardened of cynics, medical training has long been synonymous with suffering. This view, perpetuated throughout history, popular media, and doctors themselves, is particularly evident should one mention pursuit of a surgical career. The nineteenth century Professor of Medicine, Doktor Hermann Nothnagal, is quoted as saying "Whoever needs more than five hours of sleep should not study medicine",[1] and such stoicism (and self-flagellation) has seemingly persisted over one hundred years later.

The unaccredited surgical registrar,[i] with gruelling hours, immense responsibility, and no guarantee of progression to accredited trainee,[2] remains a bastion of these historic beliefs in many eyes.[3-6] In fact, for countries such as the United States, Canada, and the United Kingdom, these "service positions" do not exist as seen in Australia.[5] Therefore, this liminal role, including ward work, on call obligations, and with potentially minimal actual theatre time,[2] bolsters a healthcare system that may collapse without it.[3]

But is there any merit to the suffering, as many figures will have us believe? Is it an inevitable result stemming from the structure of the Australian healthcare system? Is it indeed fair? Ultimately, any question of fairness is subject to individual biases, over the span of time and contexts. However, in a world that has seen dramatic shifts in values and priorities for work-life balance following the pandemic,[7] are the costs of unaccredited uncertainty, including potential financial, physical, and psychological harms,[8] worth the chance of one day becoming a surgeon?

I. Unaccredited

Before assessing the fairness of the unaccredited role, it would be appropriate to first contextualise how and why these positions came to exist within the Australian public health system.

Unsatisfied in part with a lack of capacity in public hospitals for doctors to progress from basic surgical trainee (BST) to specialist surgical trainee (SST), a new program of Surgical Education and Training (SET) was introduced in 2008.[9] Previously, trainees were expected to complete two BST years and relevant examinations before progression to speciality advanced training.[10] However, hospital administrators were increasing the number of BST positions to meet service requirements, without proportionate matching of available SST positions.[10] As such, conflict between hospitals (primarily seeking service provision), and trainees and colleges (primarily seeking quality, timely training) was inevitable. Therefore, this new system ushered hope that "a more efficient and better outcome will be achieved for trainees, their trainers and their patients."[10]

However, the structural limitations within the public health system that initially prompted change remained, leading to the proliferation of unaccredited registrars facing similar problems to that of the BSTs. In formulation of this new system, unaccredited registrars do not exist within the protection of SET, instead becoming the workhorse of service provision for the hospital.[10] There is no definite time limit on their appointment, although one hopes to swiftly move through to accredited training with appropriate experience. However, the prospect of being a post-graduate year (PGY) 10+ service registrar is a potential reality for many.

In particular, when formulating the new SET program, there existed an implicit assumption that many medical officers will apply in PGY2, hence the lower overall percentage weighting of curricula vitae (CVs) at 15-20% of the application.[10] For many, the thought of a successful SET application in PGY2 today would not only be an anomaly but for many an absurdity, as requirements for terms, research, and attainment of essential surgical skills[11] may not be feasible so early in one's career. In fact, successful selection for training in some states for General Surgery, Urology, and Vascular Surgery averages approximately PGY6+, with Plastic & Reconstructive, Orthopaedic, Otolaryngology Head and Neck, and Paediatric Surgery reaching PGY7+ for the majority of trainees in 2019.[12] It would not be surprising if it takes even longer now.

Having said that, additional clinical experience can clearly facilitate broader knowledge and competency. This has formed the basis of the Australian system, with two prevocational years and rotations in various specialties. Unlike countries such as Canada and the United States, medical students do not decide their specialty of choice whilst still in medical school.[13] As such, multiple general years following medical school graduation allow for broader knowledge and development. There are clear merits to the Australian system, including allowing more time for junior doctors to decide on their preferred speciality, as well as to build upon their resume, especially if they did not have the financial means to do so during medical school. However, the

[i] There are many terms used to describe unaccredited service registrars. Sydney Local Health District and the NSW Ministry of Health prefers the term "trainees in unaccredited positions."[2] For brevity, *trainees in unaccredited positions*, *unaccredited registrar*, *unaccredited trainee,* or *service registrar* are used interchangeably, and refer specifically to those in surgical specialties unless otherwise specified.

time it takes to become a specialist, especially in surgical specialties, is considerably longer in Australia. This has forced many to question whether this is efficient for the system, but also whether it is fair for junior doctors.

II. Underutilised

For proponents of 'free market forces', the unaccredited market may be representative of simple supply and demand, and one that will self-correct with time. Instead of toiling away for a decade without attaining a training position, rational individuals will instead transition to other areas of significant need in the Australian healthcare system, such as General Practice.[14] For many, this explanation may be enough to conclude that it is not unfair for unaccredited registrars to fill these positions with no guaranteed progression and no definitive exit. However, the fact that this transition has not seamlessly occurred indicates this to be a flawed, normative theory, in behavioural economics terms.[15] Although one might believe this is how people should be behave, it is not, in fact, how they ultimately do. When constructing an efficient system, understanding individuals' actual decision-making is essential. As such, this assumption may instead contribute to an inefficient health system, especially should some unwavering and intrinsic hope for a surgical career prevent consideration of the other available specialties. Therefore, for the profit motivated individual, does prolonging hope in attaining an oversubscribed subspeciality surgical training position actually promote maximal efficiency, for both the individual and society? Or would these registrars be better utilised elsewhere and earlier?

Despite acknowledgement and general government consensus, doctors and patients alike are cognisant of the clear undersupply and unsustainable primary care system in Australia.[14] Gaps in remuneration between other specialties and rising costs in running a general practice have inevitably contributed to reduced incentives for medical graduates to pursue this career more recently.[14] Although there often exists some intrinsic passion for surgery, a better funded primary care system may entice select unaccredited registrars to this alternate training pathway through personalised cost-benefit analysis, and sooner in their post-graduate journey. This may therefore be considered more efficient, and fair, for the system and the junior doctor themselves long-term.

Conversely, this only reflects half the story. The current system relies heavily on the work of unaccredited surgical registrars, from assisting with outpatient clinics, on call hours, and managing a ward efficiently. Would de-incentivising people from persisting with these roles actually undermine the public hospital structure?

Overall population growth and an aging population places additional pressure on the healthcare system, with healthcare budgets ballooning to accommodate.[16] Additionally, structural shortfalls that have existed for years became overt during the COVID-19 pandemic, such as increases in elective surgery waiting periods.[17] One study examining an Orthopaedic outpatient clinic found an increase in face-to-face clinic volumes by 18.9% between the years 2018 to 2022, or an additional 361 patients each year.[18] In the same period, there were no additional staffing provisions.[18] Whether or not these demands surpass that of the need for Rural Generalists and General Practitioners, there clearly remains demand for the work of unaccredited registrars within surgical subspecialties alike. As with anything, more research is needed, but if highly skilled and capable unaccredited registrars are crucial for maintaining the system in parallel to trainees, it does seem unfair that they are not left with any guarantee of progression in their careers in return.

With the increase in post-graduate medical students, and an average age of twenty-four at time of enrolment in some universities,[19] an efficient General Surgery trainee may not finish SET training until their mid to late thirties. In fact, approximately 40% of SET trainees were thirty-five or older in 2022.[20] Considerations for time away for study and research, family planning, unexpected health concerns, or even the need for multiple fellowship years, can dramatically add to the total length of time it takes to become a consultant. For a system that only cares for maximising efficiency, one must consider whether this is the best utilisation of time and resources in the long-term, and if these registrars would instead better serve society with additional years as a consultant compared to their current years in service provision.

Additionally, the unaccredited position, being one to meet the needs of the hospital, has limited contractual obligations for ensuring continued medical education. They exist outside a formal training network, lacking the organised educational requirements, curriculum, or supervision of that of an accredited trainee. Likewise, healthcare services themselves, managing a hospital system in which the majority of teaching clinicians and trainees are employed, lack explicit accountability for ensuring continued education.[21] This not only reflects a potential loss in productivity but potential risk to patients. Concerns regarding this have been raised, resulting in a number of pilot programs such as the Hospital Skills Program (HSP) and Professional Development Plan (PDP) by New South Wales (NSW) Health, with varying success.[22]

As such, additional unaccredited years may further reflect diminished returns, both to the individual and long-term cost to system, past a certain point. Inevitably, different specialities and

experienced practitioners will differ in their opinion of what is the most efficient. Particularly, for those who have suffered and come out the other side, it is not unpredictable, and indeed an expected human reaction, to believe others can and should endure the same. For some, the additional time and experience may make them a better, safer, and more skilled doctor.[5] In fact, the other side to the story is that one may consider it equally unfair for those who have successfully completed training to be left with no prospect of a consultant job due to increases in trainee numbers. This is an important structural consideration. As such, it may not be as simple as increasing training positions without oversight, and there are several barriers that have been acknowledged in similar discussions previously.[4] The standards of accreditation, quality of training, access to sufficient caseloads, and availability of suitable supervisors represent some of these considerations.

In understanding the role of the unaccredited registrar, one must examine whether it is not only unfair for the individual, but concurrently unfair and incredibly inefficient for the system more generally. To have skilled, intelligent individuals spend their most productive working years in a subspecialised service job that does not offer any guarantee of progression, potentially even losing the general medical knowledge that was once touted as the key benefit of the Australian system: it seems they are additionally underutilised.

III. Unaccounted For

Despite much of the discussion so far revolving around the structure and economic capabilities of the current system, and whether this surpasses any consideration of fairness, little has been said of the actual experience for those left to face this stark reality. Although some thought for unaccredited registrars had been percolating years prior,[4, 5] their true blight perhaps first reached public consciousness in 2019 with the account on Dr. Yumiko Kadota's blog[23] and subsequent book.[24] Detailing the long hours, sleep deprivation, and obligations of a Plastic and Reconstructive Surgery service registrar, it ultimately culminated in a harrowing account of exhaustion, disconnect, and thoughts of self-harm.[24] Although only one individual's experience, it evidently resonated with others in the medical community.[3, 6] The NSW Ministry of Health began a review of trainees in unaccredited positions in 2019, with the intent to greater understand the experience of these doctors, identify issues to be addressed, and make suitable recommendations.[2] Despite this, the highly fractionated governing of medical education, speciality training, and hospital administration represents a considerable barrier, with multiple competing interests.[4]

The experience of poor mental health, depression, and burnout is certainly nothing new for doctors. A *beyondblue* survey in 2013 found that the level of general distress and suicidal thoughts amongst doctors was high, and greater than that of the Australian general population.[25] We are often reminded, even as medical students, that we must take care of ourselves before we can take care of our patients, and yet this does not always appear to be the case. In particular, a fear of being perceived as weak, a burden, and not committed enough for the job prevents individuals from seeking help.[26] Further, burnout has substantial implications for the functioning of the healthcare system, as its characteristic features of cynicism, mental distance from one's job, and reduced professional efficacy[27] can have profound effects on individuals, colleagues, and patients.[28]

Despite the physical and mental demands of long hours, a less tangible impact on mental health is the uncertainty that goes hand in hand with being an unaccredited registrar. Not only do they not know if they will make it onto the program, but they must apply for the next unaccredited job at the end of their often-yearly contract. A study examining the impact of applying to specialty training found a negative impact on the ability to exercise, explore non-medical interests, and spend time with partners and non-medical friends.[8] The very same lifestyle factors that are often prescribed for patients in their healthcare and recovery. Despite the competitiveness and gruelling 'residencies' seen in North America, their fixed length and clear requirements offers one thing to be desired. Like the Olympic sprinter, they can see the finish line at the end of the track, and know the pain will ultimately be short lived. There is much to say about the experience of suffering with and without an end in sight.

Changes in speciality selection criteria have attempted to mitigate some of the issues unaccredited registrars face. Placing limits on applications, for example, as seen in Vascular Surgery, unequivocally indicates it is time to move on.[29] Likewise, some specialties, such as Plastic and Reconstructive Surgery, are implementing points for other non-accredited surgical experience outside their specialty, to facilitate alternative career options once the maximum number of attempts is reached.[30] Contrastingly, the Australian Orthopaedic Association recently removed limits on the number of attempts, citing increased demand for training places.[31] Although limits on application attempts would seem a natural response to increasingly untenable unaccredited years, it may have the opposite effect, forcing applicants to delay their application in order to maximise competitive CV requirements. Despite this, unaccredited registrars remain

particularly vulnerable, especially to burnout. As this is an occupational health phenomenon,[27] it requires the assistance of occupational intervention, such as cultural change.[28] Until then, the suicide rate among doctors remains a stark reminder of how quickly it can all fall apart.[32]

Conclusion

And so, is it fair? In the end, the "stoics" will agree that none of us are guaranteed anything in life, no matter what is endured. However, beyond such ideological musings, one hopes that as a society we could more greatly empathise with those who are left to endure. The opportunity costs, the undercurrent of uncertainty, and the intrinsic loss of hope for a career that may never be realised, perhaps culminating in self-harm or suicide: it does not seem fair. The purpose of this essay has not been to solve a complex problem that has existed for many years, but to consider its evolution and eventual outcome as a facet of fairness. As such, it would be naïve of a medical student to speak definitively on such matters, and to claim to fully understand the nuances of a system they are yet to partake in. But a system that has contributed to the suicide of even one doctor is a system that has failed. And it is on that, we must ultimately reflect.

References

1. Markel H. *An Anatomy of Addiction*. United States of America: Pantheon Books, 2011.
2. NSW Ministry of Health. Review of Trainees In Unaccredited Positions - Discussion Paper. 2020: 1-14. Australia: NSW Ministry of Health. https://www.health.nsw.gov.au/workforce/culture/Pages/review-trainees-unaccredited.aspx.
3. Smith P. The Hidden Lives of Australia's Unaccredited Registrars. Australian Doctor Group, Australia. (2023, accessed 19/07/2024). https://www.ausdoc.com.au/news/the-hidden-lives-of-australias-unaccredited-registrars/.
4. Mitchell R, Milford WJ, Bonning M, et al. Unaccredited registrar positions in Australian public hospitals: is it time for a rethink? *Australian Health Review* 2013; 37: 409-411. DOI: 10.1071/AH13009.
5. McNamara S. Does it take too long to become a doctor? *Med J Aust* 2012; 196: 528-530. DOI: 10.5694/mja12.10619.
6. Lindsay T. Time to End Unaccredited Registrar Positions. InSight+, Australia: Australasian Medical Publishing Company. (2019, accessed 19/07/2024). https://insightplus.mja.com.au/2019/5/time-to-end-unaccredited-registrar-positions/.
7. Morgan K. What does work-life balance mean in a changed work world?. BBC, United Kingdom. (2023, accessed 25/07/2024). https://www.bbc.com/worklife/article/20230227-what-does-work-life-balance-mean-in-a-changed-work-world.
8. El-Mohamed J, Tissot S, Hart O, et al. The psychological impact of applying for specialty training: a comparison between surgery and other specialties. *ANZ J Surg* 2023; 93: 459-461. 20221211. DOI: 10.1111/ans.18203.
9. Amott DH and Hanney RM. The training of the next generation of surgeons in Australia. *The Bulletin of the Royal College of Surgeons of England* 2006; 88: 320-322. DOI: 10.1308/147363506x151008.
10. Collins JP, Gough IR, Civil ID, et al. A new surgical education and training programme. *ANZ J Surg* 2007; 77: 497-501. DOI: 10.1111/j.1445-2197.2007.04171.x.
11. Royal Australasian College of Surgeons. Essential Surgical Skills. 2015: 1-19. Australia: Royal Australasian College of Surgeons. https://jdocs.surgeons.org/essential-surgical-skills-document.
12. Queensland Government. Explore Specialties. Queensland, Australia, https://medinav.health.qld.gov.au/specialties/ (2024, accessed 20/07/2024).
13. Pollett WG and Waxman BP. Postgraduate surgical education and training in Canada and Australia: each may benefit from the other's experiences. *ANZ J Surg* 2012; 82: 581-587. DOI: 10.1111/j.1445-2197.2012.06172.x.
14. Jackson Am C. Big talk, little action: the enduring narrative of primary care reform. *Australian Health Review* 2024; 48: 219-221. DOI: 10.1071/AH24090.
15. Angner E. *A Course in Behavioral Economics*. 2nd ed. United Kingdom: Palgrave Macmillan, 2016.
16. Parliamentary Budget Office. Australia's Ageing Population: Understanding the fiscal impacts over the next decade. 2019, p. 1-22. Australia: Commonwealth of Australia. https://www.pbo.gov.au/publications-and-data/publications/research-reports/australias-ageing-population.
17. Looi JCL, Allison S, Bastiampillai T, et al. Supply and demand - a health economic perspective on the Australian hospital and elective surgery crisis. *Australian Health Review* 2023; 47: 391-393. DOI: 10.1071/AH23048.
18. Atkinson M, Wang K, Kovac N, et al. Tackling efficiency in a high demand orthopaedic clinic. *ANZ J Surg* 2024; 94: 222-228. DOI: 10.1111/ans.18828.
19. The University of Sydney. Doctor of Medicine, https://www.sydney.edu.au/medicine-health/study-medicine-and-health/postgraduate-courses/doctor-of-medicine.html (2024, accessed 24/07/2024).
20. Royal Australasian College of Surgeons. Activities Report 2022. 2022: 1-65. Australia: Royal Australasian College of Surgeons. https://www.surgeons.org/Resources/reports-guidelines-publications/workforce-activities-reports.
21. Dowton SB, Stokes ML, Rawstron EJ, et al. Postgraduate medical education: rethinking and integrating a complex landscape. *Med J Aust* 2005; 182: 177-180. DOI: 10.5694/j.1326-5377.2005.tb06649.x.
22. Thistlethwaite J, McGirr L and Vial T. Developing and evaluating a professional development plan pilot for doctors in unaccredited posts: A pilot study. *Health Education in Practice: Journal of Research for Professional Learning* 2023; 6: 1-18. DOI: 10.33966 /hepj.6.1.17077.
23. McKinnell J. Sydney surgeon quits dream job after seeing 'the dark side' of profession. ABC, Australia. (2019, accessed 20/07/2024). https://www.abc.net.au/news/2019-02-06/sydney-surgeon-doctor-hours-unsw-yumiko-kadota-stress/10784238.

24. Kadota Y. *Emotional Female*. Australia: Viking, 2021.
25. beyondblue. National Mental Health Survey of Doctors and Medical Students. 2013: 1-152. Australia: beyondblue. https://medicine.uq.edu.au/files/42088/Beyondblue%42020Doctors%42020Mental%42020health.pdf.
26. McCormack AI. A perfect storm: towards reducing the risk of suicide in the medical profession. *Med J Aust* 2018; 209: 378-379. DOI: 10.5694/mja18.00221.
27. World Health Organization. Burn-out an "occupational phenomenon": International Classification of Diseases, https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases (2019, accessed 23/07/2024).
28. Levi E. Managing oneself before managing others: a health advocacy core competency. *ANZ J Surg* 2019; 89: 1494-1496. DOI: 10.1111/ans.15545.
29. Australian and New Zealand Society for Vascular Surgery. Selection Regulations: Surgical Education and Training in Vascular Surgery 2025 Intake. 2024: 1-8. Australia: Australian and New Zealand Society for Vascular Surgery. https://anzsvs.org.au/education-training/selection/.
30. Australian Society of Plastic Surgeons. Selection for SET, https://plasticsurgery.org.au/about-asps/becoming-a-specialist-plastic-surgeon/selection-for-training/ (2024, accessed 22/07/2024).
31. Australian Orthopaedic Association. Changes to Selection for the 2025 Intake, https://aoa.org.au/orthopaedic-training/selection-into-training/2025-intake-changes-to-selection (2024, accessed 19/07/2024).
32. Bailey E, Robinson J and McGorry P. Depression and suicide among medical practitioners in Australia. *Intern Med J* 2018; 48: 254-258. DOI: 10.1111/imj.13717.