

Independent Review of Accreditation Systems
within the National Registration and Accreditation Scheme
for health professionals

Submission
Medical Deans Australia and New Zealand
May 2017

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Introduction

Medical Deans Australia and New Zealand (Medical Deans) welcomes the opportunity to provide a submission to the Independent Review of Accreditations Systems within the National Registration and Accreditation Scheme for health professions. Medical Deans is the professional body representing entry level medical education, clinical training and research in the 21 Australian and New Zealand universities with medical schools. The discussion paper posed 37 questions and this submission responds to the questions which are most relevant to Medical Deans. Individual medical schools were consulted and provided input for this submission.

Public safety and professional quality is the paramount objective of the National Registration and Accreditation Scheme. The Australian Medical Council (AMC) develops accreditation standards, policies and procedures for primary medical education programs and assesses education providers and programs of study based predominantly in Australia and New Zealand. The purpose of AMC accreditation is to recognise medical programs that produce graduates competent to practice safely and effectively under supervision as interns in Australia and New Zealand. The AMC process entails both accreditation to validate that standards are met and peer review to promote high standards of medical education.

Medical Deans believes the AMC is a very professional and competent organization and its accreditation processes are well organised, consultative, effective and rigorous. They add real value to the programs being accredited as they have both a quality improvement and quality assurance purpose.

It is important this is maintained and enhanced, as quality assurance systems can cause harm if done poorly. According to the person widely regarded as the father of quality assurance systems in health, poor quality assurance systems may result in: *'dilution of professional responsibility, distortion of professional judgment, stereotyping of practice, discouragement of innovation, legal hazard and an ambience of fearfulness that leads to resistance, evasion, concealment and ultimate demoralization.'* [ref: Donabedian A. The effectiveness of quality assurance. *Int J Qual Health Care*. 1996 Aug; 8(4):401-7]

Good quality assurance systems involve much more than merely furnishing evidence to satisfy an external party of achievement of a minimum standard. Fundamentally, the process should drive reflective and peer-supported continuous improvement, no matter the performance baseline. This is the important alchemy of 'culture' in quality assurance systems in health; mere reporting to a central authority is no substitute for honest self reflection and authentic engagement in renewal. AMC accreditation teams comprise individuals, many of them peers, who are engaged both in appraisal of others as well as in exchange of learning about how medical education might be strengthened generally.

There is always room for improvements in any system and the responses in this submission are offered in that context.

The review is also asking the broader question of how can education and training and its accreditation, help create the workforce that Australia needs. Medical Deans is committed to improving the health of the people of Australia and New Zealand through continual development of medical education and research leading to high quality, work ready medical graduates and excellence in research. There are serious challenges facing the delivery of health services today including an aging population, the increasing burden of chronic disease, new technology, resource allocation and the intersection of Commonwealth State relations. Ensuring a well trained workforce with the right skills in the right places is critical to addressing these issues but the complex interplay between the many stakeholders and systems also make it very difficult achieve.

The accreditation system provides some opportunities to address workforce and service delivery challenges, for example the adoption of AMC standards relating to Indigenous health. Accreditors also need to be mindful of any unintended barriers to workforce reform and access created by their standards and processes. Medical Deans welcomes a focus on community outcomes in any revised accreditation and professional registration arrangements. As with the shift in focus from treatment of individual patients to effective and affordable systems of healthcare for populations, so accreditation systems can be clearer on what it is that communities are entitled to expect if professional accreditation is aligned to priority community needs. However Medical Deans acknowledges the limitations of the accreditation process in advocating and influencing health service delivery and workforce outside its primary remit.

Responses to Questions Posed in the Discussion Paper

Improving Efficiency

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards (across the 14 accreditation authorities)?

The development and application of standards for accreditation across the 14 health professions vary, including the duration of accreditation cycles, costs, choosing and training accreditation teams, and variations in terminology. Each accreditation body often requires the same information be presented in different formats and while some of the information is discipline specific, there is significant institution specific information. There are potential benefits and efficiency gains in the development and application of accreditation standards for common health profession elements overlaid with profession specific requirements.

However, the different scopes of practice of professions and the differing degree timeframes would need to be recognised and respected if some common health profession standards were to be included. The introduction of any new standards involves considerable work for education providers, so benefits would need to be significant in order to outweigh the additional work.

Potential common standards could include, for example, those addressing governance, organisational structure, feedback mechanisms to students, and multidisciplinary engagement with other professions. The benefits of greater consistency could be improved efficiency and better encouragement for inter-professional education. It could also encourage further sharing of information and information-collection-tools between accreditation bodies, which may assist in developing consistency in the templates used by accrediting bodies. Currently the variety of templates used creates additional workload for universities.

2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

Medical Deans supports the ongoing primary program accreditation process to be conducted by the relevant professional body authorities rather than through generic TEQSA/ASQA processes as they are largely for different purposes. Medical Deans acknowledges the accreditation burden for education providers is high and would support opportunities for evidence from TEQSA reports to be accepted in response to some more generic standards, for example some of the standards in learning and teaching, assessment, students support and the non-clinical learning environment. However, the TEQSA reports will not address many central aspects of primary program accreditation relevant to the health professions such as Aboriginal and Torres Strait Islander or rural quota admission pathways or cross-organisational clinical staff and clinical teaching facilities in public and private and community and hospital settings.

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and interprofessional collaboration?

Medical Deans are supportive of the current AMC accreditation processes, they are well organised, consultative, effective and rigorous. They add real value to the program being accredited as they have both a quality improvement and quality assurance purpose. The process facilitates deep discussions between the accreditor and the organisation being accredited increasing understanding of the intent behind various standards on the part of the provider as well as allowing the experience of different accreditation team members to be shared. There is always room for improvements in any system. We offer the following additional comments acknowledging that the AMC already does a number of these, but suggesting they are relevant to all professional accrediting bodies.

- Panels should be configured to include the necessary breadth and expertise to cover the standards and ensure the relevant stakeholders are accounted for as well. In the case of health professional accreditation these include the public who should receive high-quality, safe health care and students/trainees who need to be prepared through appropriately designed programs to deliver that care.

- More panel membership positions could be sourced through an EOI process to bring in new perspectives.
- Consistency could be strengthened by:
 - Requiring all accreditation teams to complete training programs based on agreed national standards for accreditation. This would ensure a trained pool of people exists from which well balanced and well prepared accreditation teams could be established.
 - Moving toward a single reporting template, paperless submissions, and a list of mandatory supporting documents.
 - Ensuring greater clarity in the templates used by accreditation bodies to reduce requests for resubmission or further information.

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

The key principles for setting fees should be:

- transparency around the actual costs of the accreditation processes; and
- the provision of a robust, comprehensive accreditation process including quality assurance and quality improvement at the lowest cost possible

The process needs to balance the quality assurance and quality improvement provided by accreditation against the resources consumed by accreditation, in order to minimise its impact on teaching budgets and innovation in education. Accreditation should not impose significant costs on students.

The balance between payment by registrants and education providers is likely to vary between disciplines and with stage of training. It should be recognised that there are significant additional overheads for universities generated by the workload of preparing the extensive documentation required and organising and conducting visits.

Relevance and Responsiveness

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

The standards against which programs of study are assessed must ensure providers are delivering health professional education and training which produces junior doctors who are competent to practice safely and effectively under supervision as interns. Outcomes based standards permit curricular innovation and Medical Deans supports the AMC approach which requires providers to demonstrate how their program enables graduates to meet the Graduate Outcome Statements but respects the diversity of curricula approaches in medical schools.

Some process standards are important in assessing a schools performance including standards on appropriate staff profiles, learning environments, social inclusion, resources and governance frameworks. Clearer process guidelines or standards about engagement with health care service providers and consumers would be useful. There can also be a role for process standards to help establish new theory and uptake in practices.

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

There are some common elements of instruction that could be a part of all health profession programs including for example in ethics, professionalism, communication skills, collaboration and teamwork. However there is a risk that standards uniformly applied to all health care professionals would result in standards that are too broad and/or superficial to adequately address the delivery particulars and outcomes of individual programs. Discipline specific outcomes need to be appropriately evidenced prior to students becoming eligible to undertake clinical practice and each provider needs to be responsible for developing its own professional competency framework, using the best evidence for that discipline.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

The newly revised first object in the AMC Constitution is: ‘to improve health through advancing the quality and delivery of medical education and training associated with the provision of health services in Australia and New Zealand.’

In regard to accreditation of universities providing medical education, the community context for ‘improving’ medical workforce should frame the broader purpose of the accreditation system. This is consistent with international directions in health workforce policy, for instance in the social mission of health education institutions, which according to the World Health Organization “represents an opportunity to nurture in health workers ... public service ethics, professional values and social accountability attitudes” [ref: World Health Organization. Global strategy on human resources for health: workforce 2030. Geneva 2016. http://www.who.int/hrh/resources/pub_globstrathrh-2030/en/]

The AMC has generally set very generic standards that go to the roles of a doctor as medical expert, communicator, leader, professional and ethical practitioner and the processes by which programs should achieve these graduate outcomes. This assists in the standards withstanding the test of time and continuing to be applicable for future models of care, new ways of working and changing health demands. The accreditation system of the AMC with its process of continuous monitoring is also responsive.

Medical Deans supports an approach which allows education providers to innovate, obviously with the caveat that there is no evidence a proposed innovation will create barriers to graduates acquiring the required knowledge, clinical skills and professional attributes.

Medical Deans also acknowledge that the development of standards has a limited role in truly addressing changing models of care and health needs - accreditation is only one component in aiding education providers to deliver fit for purpose graduates.

It is important that students, recent graduates, employers and consumers also have a role in shaping standards. The AMC process for developing standards is an excellent example of how this can be done well and ensure that key stakeholders are engaged.

13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

The current AMC Standards for Assessment and Accreditation of Primary Medical Programs already include reference to interprofessional learning, for example:

4.7 - “The medical program ensures that students work with and learn from and about other health professionals including experience working and learning in interprofessional teams.”

Medical Deans recognises the importance of team based health care delivery and the positive contribution it makes to improved health outcomes and believes the current standards are adequate in this regard. Interprofessional collaboration with shared goals is what underpins effective team based care and interprofessional education is only one part of achieving this. It is important the focus remains on the intended outcome which is the delivery of effective team based health care, not the delivery of an interprofessional educational activity. Not all interprofessional educational activities result in better team-based care; some detract from it.¹

1

A study by Gupte, G., Noronha, C., Horný, M., Sloan, K., & Suen, W. (2016). Together we learn: Analyzing the interprofessional internal medicine residents’ and master of public health students’ quality improvement education experience, *American Journal of Medical Quality*, 31(6), 509-519 found that internal medicine residents had significantly less positive attitudes towards IPL than Master of Public Health students after IPL curriculum was introduced at a working medical centre. This may show the potential differences in culture and learning outcomes of other health sciences and medicine, especially when applied to practice. Studies have also shown that students have less positive attitudes (and scored lower points) to teamwork and collaboration, professional identity and patient-centredness aspects of the Readiness for Interprofessional Learning Scale (RIPLS) after experiencing early interdisciplinary clinical experience (Hudson, J. N., Lethbridge, A., Vella, S., & Caputi, P. (2016). Decline in medical students’ attitudes to interprofessional learning and patient-centredness, *Medical Education*, 50(5), 550-559). However, other studies have shown that different medical cohorts had more positive

There are some common curricular domains (e.g. professionalism, leadership, communication, research skills) across many health professional degree courses and a common approach in these areas may be achievable. However interprofessional learning opportunities need to be real and not contrived and can be extremely resource intensive to deliver. One of the significant barriers to interprofessional education is the logistical difficulty of delivering interprofessional programs to students enrolled in multiple courses, particularly in clinical settings. For example, timetabling an interprofessional activity between nursing students and medical students must account for the timetables of the two different organisations the students belong to as well as the clinical demands of the health facility in which the activity is to take place. The complexity of achieving this should not be underestimated.

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

Medical Deans supports a broad outcomes based approach which enables individual schools to find the best way to meet the outcome appropriate to their circumstances and local community. There is a risk that if standards become too prescriptive in an effort to address health care priorities, it may result in a micromanagement of courses at a subject level that is labour intensive and does little to achieve the end goal.

It should also be recognised that while there will be similarities across Australia and New Zealand, there will also be different health care priorities and areas of workforce. A “one size fits all” approach may hinder development rather than enhance opportunities across either country. The 22 medical programs in Australia and New Zealand offer a diversity of entry pathways, targeted recruitment cohorts, undergraduate and graduate degrees, timeframes and geographic locations to provide Australia and New Zealand with doctors who are suited to provide health care services in a range of settings and specialities. Higher order competencies could be integrated to the outcomes, for example - ability to analyse health care systems, populations etc.

Medical Deans are supportive of expanded clinical placement opportunities outside non traditional settings. This is reflected in the current AMC Standards which state in 8.3.2 “*The medical education provider has sufficient clinical teaching facilities to provide clinical experiences in a range of models of care and across metropolitan and rural health settings.*”

Clinical training and experience developed through clinical placements is a critical component of primary medical education and essential to developing work ready graduates. However ensuring sufficient and appropriate clinical placements is an increasing challenge - the growth in the number of students in health related disciplines has put pressure on clinical training capacity and the loss of the Clinical Training Fund in 2015 has exacerbated this.

Clinical placements are typically resourced through combined direct and indirect contributions from government (both state and federal), education providers and health services. A diversity of arrangements for placements across jurisdictions and disciplines exist between universities and health service providers.

While there is a role for the accreditation system, changes to the accreditation system, will not in and of themselves address many of the barriers (for example, funding, Commonwealth State responsibilities, lack of supervision) that prevent more appropriate clinical training aligned to health care priorities.

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

The provider has the prime responsibility for determining how best to incorporate contemporary education practices such as simulation or other technology- based education. The accreditation body should determine the appropriateness of these at the time of review. Important components required

attitudes of IPL experiences after qualitative analysis of written reflections (Luebbbers, E., Dolansky, M., Vehovec, A., & Petty, G. (2017). Implementation and evaluation of a community-based interprofessional learning activity, *Journal of Interprofessional Care*, 31(1), 91-97.

for success are the training of educators, adequate support staff as well as curricular space and physical facilities. The current standards examine these domains. Opportunities to share simulation resources should be encouraged and could contribute to interprofessional learning. The accreditation process can be used to encourage innovation, provide scope to showcase and commend innovative teaching practices, and stimulate research. This potential is already embedded in the AMC approach.

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

Yes given the different scopes of practice for each profession. Patient safety is paramount as practitioners take up practice from training. Supervision provides the opportunity for evaluation of trainees' application of skills and knowledge as they enter real world practice. A period of supervised practice is highly desirable for a number of health professions to ensure safe clinical care. Medical Deans believe that PGY1 is an essential transition phase where junior doctors take on the responsibilities of being a doctor and learn to be a member of the health care provider. Each discipline is better placed to determine such standards.

17. How should work readiness be defined and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Medical Deans recognise the desire for an agreed understanding of the work readiness for graduates before they commence internship. The Review of Medical Intern Training recommended that the internship should have entry requirements that reflect agreed and defined expectations of work readiness that graduates must meet before commencing. The threshold issue is the definition of work readiness.

There are different understandings as to what is meant by work readiness. While there would be general agreement work readiness involves a graduate being able to complete a hospital prescribing form there would be varying views on whether it requires being aware of the human resource department requirements of different health services.

Assessing work readiness is also complex. It requires the specification of the instruments that will be used for that purpose; standard setting the assessment at an appropriate level for a medical student; development of related assessment tools; determination of appropriate assessors; training and calibration of assessors to ensure a consistent approach.

Universities and health services are working more closely together on the issue of work readiness and in 2016 a National Intern Work Readiness Forum was jointly hosted by Medical Deans and the Health Workforce Principal Committee. The forum brought together key stakeholders to identify the expectations of medical practitioners as they transition to practice and consider options for assessment of those defined capabilities. This work is ongoing.

Medical Deans could support the use of Entrustable Professional Activities (EPA's) in some form to define work readiness but any changes would need to link to the AMC Graduate Outcome Statements, respect the diversity of approaches in medical schools and not increase the overall burden of assessment in medical school programs, which is already quite high.

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

Yes, a robust accreditation process does negate the need for further national assessment. Accreditation has a much broader purview than assessment and looks at all aspects of a curriculum, its governance and its responsiveness to changes in the health of a population. Importantly, particularly in the case of the AMC, it also drives quality improvement.

A national assessment process is expensive and can only measure performance at a point in time. This type of examination is usually very knowledge based rather than assessing the full breadth of what a medical student knows and can do. The breadth of competencies required to practice in health care make it very challenging to have a meaningful national assessment. National assessments can also be a significant inhibitor to innovation and encourage the teaching of a set type of content to address the perceived requirements of the national examination rather than medical education being cognisant of and responsive to the health needs of the community. Our system at the moment accredits against

common standards, but facilitates education providers shaping their programs and assessments to meet specific and sometimes different community needs such as those encountered in rural and remote or outer metropolitan communities.

Medical Deans is involved in a number of assessment benchmarking projects which assist school's to improve medical course assessment and demonstrate quality graduate outcomes.

Producing the Future Health Workforce

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

Medical Deans believes the close alignment of the health professional educational programs with the standards expected of a practicing health care practitioner as determined by the national board is essential for medical schools to ensure all graduates meet the professional standards expected of them in clinical practice. Attaining the requisite educational standards at medical school is fundamental to ensuring graduates are fit to practice as a medical practitioner.

The National Law adequately articulates the division of roles and functions between the national board and the delegated accrediting authority with respect to the program accreditation functions. This additional oversight of the accreditation standards and outcomes by the National Board is likely to provide the public with an additional assurance that at all levels, assessment activities are undertaken to ensure and demonstrate that medical graduates from Australian medical schools are of a high and consistent standard.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

In order to optimise the benefits that flow from sound accreditation processes, governance arrangements need to strike a careful balance between "arms length" approaches to managing real or perceived conflicts of interest while ensuring that those charged with decision making are able to access critical information from all key stakeholders. Accreditation decisions not so informed have the potential risk of driving superficial activity. Medical Deans believes the AMC structure, where the Directors are the key decision makers but able to inform themselves from the deliberations of a broader Council that includes a mix of key stakeholders is an effective and robust model which achieves the right balance.

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- **Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards.**
- **Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards**

Medical Deans believe it is important to have a medical accreditation agency that accredits across the continuum of medical education including entry level, prevocational and vocational training and does not support a single national accreditation organisation for all professions. Medical Deans agrees that education needs to support the development of a workforce that is flexible, responsive and sustainable. However making accreditation agencies bigger and potentially more cumbersome will not produce innovation. Discipline specific accreditation is more effective and usually more efficient.

Expanding the remit of the AHPRA Agency Management Committee may help improve consistency and encourage interprofessional education, particularly if it were able to influence the behaviour of accrediting bodies for the non-registered professions.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions that:

- **As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?**
- **Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?**

Medical Deans acknowledges the difficulty in identifying the key levers and drivers required for reform in such a complex space that contains a myriad of funders, policy makers, trainers/educators and health care providers. Health Workforce Principal Committee and/or National Medical Training Advisory Network (NMTAN) potentially provide vehicles where important workforce reform issues could be addressed.