Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions

May, 2017

To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.
ANZCA submission to the *Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions, 2017*

**About the Australian and New Zealand College of Anaesthetists (ANZCA)**

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional organisation for specialist anaesthetists (Fellows) and specialist anaesthetists in training (trainees) in Australia and New Zealand.

This year, ANZCA celebrates its 25th anniversary as a medical college though its history stretches back 65 years to when it was established in 1952 as a faculty of the Royal Australasian College of Surgeons.

ANZCA is now a world-renowned institution in anaesthesia and pain medicine and has taken a leading role in many areas of anaesthesia, pain medicine and intensive care medicine. This includes:

- being recognised as a world leader in the treatment of pain, by establishing the specialty of pain medicine through its Faculty of Pain Medicine
- setting high professional standards for patient safety through professional documents and other advocacy activities
- answering key questions in medical research by recruiting more than 30,000 patients to help with $A25 million worth of studies for the ANZCA Clinical Trials Network; and other research through the ANZCA Research Foundation, which in 2017 alone is funding research worth $1.7 million
- training highly skilled future Fellows in anaesthesia and pain medicine
- hosting more than 30 medical education events annually including the College’s flagship event, the ANZCA Annual Scientific Meeting
- supporting anaesthesia in developing nations such as Papua New Guinea with clinical and educational visits; and the seeding of the Essential Pain Management program, now being taught in 47 countries
- establishing intensive care medicine as a specialty by instituting training and accreditation programs through a joint Faculty of Intensive Care, and then helping to found the College of Intensive Care Medicine of Australia and New Zealand.

ANZCA, including FPM, is committed to high standards of clinical practice in the fields of anaesthesia, perioperative medicine and pain medicine. As the education and training body responsible for the postgraduate training programs of anaesthesia and pain medicine for Australia, New Zealand, and parts of Asia the College believes in ongoing continuous improvement and strives to ensure that its programs represent best practice and contribute to a high quality health system.
ANZCA’s mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine. From this mission flows three major objectives:

- To promote professional standards and patient safety in anaesthesia, perioperative medicine and pain medicine
- To promote training and education in anaesthesia, perioperative medicine and pain management
- To advance the science and practice of anaesthesia, perioperative medicine and pain management.

Australia-wide there are 5647 active and 840 retired Fellows, 34 SIMGs and 1217 trainees. There are 769 Fellows and 255 trainees in New Zealand.

**About the Faculty of Pain Management (FPM)**

The Faculty of Pain Medicine (FPM) is the professional organisation for specialist pain medicine physicians (Fellows) and specialist pain medicine physicians in training (trainees).

- FPM is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand. Formed in 1998, the Faculty is the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine. Although part of ANZCA, the Faculty’s fellowship and representation remains multidisciplinary at all levels.

FPM arose out of collaboration between five participating bodies – ANZCA, the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons, the Royal Australian and New Zealand College of Psychiatrists and the Australasian Faculty of Rehabilitation Medicine (AFRM) of the RACP.

In 2005, the discipline was recognised in Australia as a medical specialty in its own right and was accredited as a scope of practice in New Zealand in 2012. This highlights the importance of the problem of unrelieved pain in the community and the need for a comprehensive medical response through education, training and practice.

The field of pain medicine recognises that the management of severe pain problems requires the skills of more than one medical craft group. Such problems include:

- Acute pain (post-operative, post-trauma, acute episodes of pain in ‘medical conditions’)
- Cancer pain (pain directly due to tumour invasion or compression, pain related to diagnostic or therapeutic procedures, pain due to cancer treatment)
- Persistent (chronic) pain (including over 200 conditions described in the International Association for the Study of Pain (IASP) Taxonomy of Chronic Pain 2nd Edition, such as phantom limb pain, post-herpetic neuralgia, lumber discogenic pain). Chronic pain affects one in five Australians.

In Australia and New Zealand, a career in pain medicine is generally obtained by qualifying as a Fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA). FFPMANZCA is an additional specialist qualification available through training to those with background qualifications in a range of specialist areas including general practice.

Fellows of FPM have a wide knowledge of the clinical and humanitarian aspects of pain and are trained in the use of a sociopsychobiomedical framework. They are therefore well-placed to follow a developing and challenging career path.
World recognition for the Faculty was achieved through award of the 2017 American Academy of Pain Medicine’s (AAPM) Robert G. Addison, MD Award, given in recognition of outstanding efforts to foster international cooperation and collaboration on behalf of the specialty of pain medicine. The European Pain Federation is now also using FPM’s revised curriculum as the basis for its diploma.

Australia-wide there were 387 active and 32 retired Fellows, 58 trainees and 3 SIMGs. There are 37 Fellows and 9 trainees in New Zealand.

ANZCA involvement in accreditation

As the fourth largest specialist medical college in Australia, ANZCA is monitored against the accreditation standards of the Australian Medical Council (AMC). Under the AMC framework, ANZCA already applies outcomes-focused and risk management approaches to accreditation. This occurs at both curriculum and hospital site levels to ensure our trainees are developed to the required standard and meet the future demands of the health sector.

ANZCA broadly supports the current AMC accreditation system, which provides the College with an opportunity to build efficient and effective mechanisms to monitor the quality and outcomes of our education and training activities into our work. The College’s approach focuses on patient safety and developing a future medical specialist workforce with the required competencies and knowledge to meet the community’s needs.

The longest potential accreditation review period offered by the AMC is 10 years (that is, 6 years with a 4-year extension). ANZCA’s review period was recently extended by 4 years, with a watching brief on emerging risks. This confirms that ANZCA is a high performer within the current accreditation system.

ANZCA supports a focus on outcomes, quality and continuous improvement in accreditation systems, and this will continue as the AMC utilises new online technology to automate some of its monitoring and reporting processes and help reduce both duplication and the cost of administration systems.

General comments

While ANZCA is aware of a range of issues regarding the Terms of Reference for this discussion paper, it is unable to provide specific commentary of many of these as they are not within the College’s scope of activity.

The following general comments are provided for consideration by the Australian Health Minister’s Advisory Council:

Cost-effectiveness of the regime for delivering the accreditation functions

Accreditation incurs substantial costs for specialist medical colleges. ANZCA believes that the costs and overheads for delivering accreditation functions should be reduced. For ANZCA, the cost of participating in accreditation is estimated to be greater than $150,000 per accreditation cycle. This is an expense that is significant for a membership-based organisation that does not have government funding support for its operations. Therefore, the College relies significantly on training fees and an internal volunteer workforce to conduct the required accreditation tasks.

Any increase in future accreditation costs for the College would be fully borne by the ANZCA trainees and the SIMGs undertaking the New Fellowship Pathway. Cost implications for trainees and the College’s voluntary workforce are important considerations when proposing any changes to accreditation systems relating to specialist medical colleges.
Governance structures including reporting arrangements

ANZCA operates within an outcomes-focused and knowledge-based training and accreditation system that is designed to focus on the needs of a competent anaesthesia and pain medicine workforce. ANZCA would not support accreditation of vocational training processes becoming more prescriptive.

ANZCA does suggest, however, that there should be a clear delineation of responsibility between the National Board, specialist colleges and postgraduate medical councils. Relationships between these entities should be more collaborative, with less duplication and greater consistency of process.

For example, in February 2016, the Australian Medical Council delivered an event entitled ‘Engaging stakeholders in delivering high quality medical training and education’. This was an invaluable event and reflective of AMC’s agenda for collaboration. The event enabled specialist medical colleges to discuss AMC standards, AMC processes, opportunities for specialist medical colleges to share experiences concerning accreditation methods, and monitoring and evaluation tools. The outcome of the event for ANZCA was positive with immediate practical advice, ensuring that ANZCA is efficient and effective and also providing immediate feedback to AMC to ensure that its processes and approach evolve.

Responses to specific questions in the ‘Consolidated list of issues’

Q1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

- The AMC has demonstrated the benefits and potential cost savings of an integrated approach across all medical disciplines and levels of training (primary degree, pre-vocational and vocational training). Adoption of the CanMEDS Framework ensures international consistency and provides the opportunity for national and international sharing of standards, approaches to competency-based medical education, research and evaluation.
- The AMC provides an example of a robust model for the development and application of accreditation standards across the medical profession.
- A document similar to the Good Practice Guidelines for the specialist international medical graduate assessment process would be of value across all disciplines, to provide high level guidance and consistent terminology while allowing for differences between the organisations being accredited.

Q2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

- The TEQSA/ASQA accreditation model is oriented towards the tertiary education system and has limited utility in postgraduate (vocational) specialist education.
- Although elements of the TEQSA/ASQA model may be applicable, these should be integrated into the AMC model rather than substituting for it.

Q3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

- The AMC approach embraces open-ended and risk-managed accreditation cycles. Using a similar approach to accreditation for all medical and healthcare training programs would be a positive step.
Q5. Should the assessment teams include a broader range of stakeholders, such as consumers?

- ANZCA agrees in principle that assessment teams should include a broader range of stakeholders, such as consumers, but there are challenges in defining who the most relevant ‘consumers’ are. There needs to be a determination on what constitutes ‘consumers’ in these instances: are these patients, healthcare clients, trainees, supervisors, SIMGs, or specialists in accreditation systems?
- While Question 5 relates to Accreditation Authority panels, we note that ANZCA has community representation at the committee level where approvals for accreditation of hospitals are granted.
- ANZCA notes that evidence of community responsiveness (including cultural safety) has been incorporated into the CanMEDS competency framework.

Q6. 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?

- Consideration could be given to requiring the AMC to establish benchmarks for fees and levies within the vocational training sector.
- Key principles for setting fees and levies for funding accreditation functions include affordability for not-for-profit, membership-funded postgraduate medical colleges. This will ensure that accreditation processes maintain their high contemporary standards of competency-based medical education; and sustainability, timeliness and responsiveness.

Q7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on-shore programs?

- ANZCA considers that burdening one group with the costs incurred by another is discriminatory. The College notes that international specialist trainees are required to pay higher fees than Australian specialist trainees.
- It is our position that fees charged for the assessment of overseas qualified practitioners should not be used for this purpose. The cross-subsidisation from the assessment of offshore competent authorities may be justifiable.

Q8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

- ANZCA supports the principle that specialist medical colleges determine the processes and inputs required to achieve the required outcomes (e.g. compliance with professional standards, quality and patient safety).

Q9. Are changes required to current assessment processes to meet outcome-based standards?

- The terms ‘inputs’ and ‘processes’ tend to be used interchangeably in the paper, which is confusing.
- ANZCA successfully achieves the outcome-focused standards required by the current assessment processes (as noted above) and does not believe that significant changes are needed.
Q10. 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?

• ANZCA supports a common approach to the development of professional competency frameworks and the inclusion of consumers in the process. Adoption of the CanMEDS framework (aligned with international standards for medical practice) by all Australasian specialist training programs is such an example (refer to AMC Standard 2.3.1).

Q11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlaid with profession-specific requirements?

Risks include:

• Clinicians will more readily adopt and comply with standards that are meaningful and credible in their own teaching, learning and practice environments.
• Standardised accreditation standards may be too generic and be difficult for each profession to interpret. It is important for each profession to have its own quality measures which are aligned with the standards.
• Training may become focused on ‘common areas’ rather than profession-specific areas that are more relevant to practitioners’ actual scopes of practice.

Benefits include:

• Greater system efficiencies where common domains exist
• Consistency in non-clinical aspects of training
• Greater public understanding of the requirements and outcomes of specialist medical training.

Q12. 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?

• Accreditation systems should consider quality measurement and engagement. Ongoing data collation using continuous improvement introduces a proactive, responsible evaluation model for accreditation - as opposed to an approach based on a retrospective cycle.
• Trainees now expect more from their trainers and colleges, so any accreditation system needs to be efficient.
• The feedback process needs to be re-modelled to include the fit-for-purpose use of technology to collect and collate feedback.

Q13. How best could inter-professional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

• Inter-professional education and interdisciplinary practice should be expressed in the accreditation standards through use of the CanMEDS framework and the CPD requirements for multidisciplinary education, and the ability to define individual training pathways.
• Where training sites provide training for multiple specialties (for example anaesthesia, surgery and pain medicine) there may be opportunities to integrate and streamline accreditation to minimise any potential impact on hospital resources.
• ANZCA is actively involved in developing pre- and post-fellowship training programs in perioperative medicine. This involves bringing together a number of medical and non-medical disciplines to provide coordinated and best practice care of surgical patients, to promote optimal patient outcomes.
There are competency statements relating to interdisciplinary care within the ANZCA training program. The extension of AMC accreditation to post-fellowship training will help to promote inter-professional education and improved inter-disciplinary practice.

Interdisciplinary practice is also integral to Pain Medicine, as reflected in the competency statements in the Faculty’s curriculum.

Q14. **How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?**

• Specialist colleges are well placed to identify and implement healthcare priorities that will develop the expertise required by the future workforce.
• It is unclear what is meant by the ‘embedding of healthcare priorities’. ANZCA would certainly support initiatives such as the surgical safety check list.
• Healthcare prioritisation is addressed in the Roles in Practice elements of the ANZCA curriculum, which adopts the Leader and Manager roles in accordance with the CanMEDS framework. Prioritisation and appropriateness of treatment is also addressed in other relevant sections of the curriculum. Similar comments apply to the Pain Medicine curriculum.

Q15. **How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?**

• Contemporary education practices, such as simulation, are currently incorporated into the curricula and clinical experience for training in anaesthesia and pain medicine.
• The training courses and learning programs being delivered by the colleges need to align with curriculum standards. ANZCA’s mandatory courses (for example the Effective Management of Anaesthetic Crises (EMAC)) are fully aligned with the College’s curriculum to ensure that the learning outcomes achieve the curriculum intent.
• There are further opportunities to explore substitution of simulation-based education for conventional clinical experience in specific areas of practice where the achievement of an appropriate volume of practice is difficult. However the cost of making high-fidelity simulation available to trainees in all training settings is likely to be prohibitive.

Q16. **Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?**

• ANZCA and FPM are only able to comment on periods of supervised practice as a precondition of registration for medical practitioners. The College does not have an understanding of the standards and requirements for supervision of trainees in allied health or nursing professions as they transition to independent practice.
• ANZCA suggests that a period of supervised practice in an employed hospital/health service/practice position is a critical precondition of general registration for medical practitioners. Currently, this is a one-year requirement (internship) in Australia.
• ANZCA requires two years of pre-vocational experience following general registration prior to gaining entry into its specialist anaesthetist training program.
• ANZCA recommends that consideration be given to extending the period of supervised practice as a pre-condition of general registration to two years (which has been adopted in New Zealand); and that the pre-vocational accreditation processes apply to all rotations during this full two-year period.
• It should be noted that pre-vocational generalist training informs career decision making and provides a critical foundation for subsequent vocational training and work-readiness.
• Provisional fellowship (as the final stage of ANZCA’s specialist training program) and the practice development stage (as the final stage of FPM’s specialist training program) are supervised periods for senior trainees.
• This respects the autonomy that trainees are entitled to as competent practitioners, but recognises that these trainees are early in their specialist careers and still lack some required experience.
• ANZCA has Fellow, SIMG and trainee re-entry to practice processes for practitioners returning to work.

Q21. Is there adequate community representation in key accreditation decisions?
• Community representatives can add value to decision-making, and when supported through ongoing education and skills training in accreditation can assist the College with its operations. ANZCA has appointed community representatives to a number of the College Committees.

Q25. 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.

• ANZCA notes that the current governance model includes National Boards (the AMC has been endorsed for medical colleges). More evidence is needed that the current system does not work well.
• AHPRA approval of accreditation standards should be managed by the AMC rather than by a single overarching agency for all health professions.
• Due to the highly specialised nature of medical colleges, a single overarching agency for all health professions would be an ineffective means of ensuring a high quality future workforce.
• It may be an option to adopt a shared services model to support individual accrediting councils. Such a model may help reduce duplication and cost, as well as increase efficiencies and standardisation, but retain the profession specific knowledge across the Councils.
• There is a need for greater coordination of accreditation standards and processes across the professions. If there is capacity for improved efficiency and standardisation across the professions, there may be a strong argument for the Agency Management Committee to have an increased mandate in setting policy and standards.

Q26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?
• The identification of specific competencies should be included in the training, CPD, and SIMG processes.
• Accreditation of the training, CPD, and SIMG processes at specialist medical colleges should be undertaken as part of the AMC’s regular accreditation of the College and its processes.

Q28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?
• The Ministerial Council should have a role in the formal consideration and adoption of proposed accreditation standards, extension of existing training courses, and establishment of sub-specialties and associated training courses.
Q31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

- ANZCA suggests there should be clear delineation of responsibility between the National Boards, specialist colleges and post-graduate medical councils and the relationships between these entities should be more collaborative. There are three principal layers in the Australian and New Zealand medical education systems:
  - Undergraduate training towards a primary medical degree (overseen by the universities).
  - Pre-vocational medical education (overseen by the pre-vocational medical councils and AHPRA and the MBA).
  - Vocational (specialist) medical training (overseen by the postgraduate medical colleges).
- The AMC has effectively implemented accreditation functions at each of these levels, appropriately tailored to the nature and context of medical training at each level.
- The AMC governance and committee structure draws representation from each level, and bodies such as Medical Deans Australia and New Zealand, the Council of Presidents of Medical Colleges, and the Confederation of Postgraduate Medical Education Councils provide input on behalf of their members.
- The AMC and the Medical Board of Australia are well-placed to oversee integration and coordination between these phases of medical training as competency-based medical education evolves and there is increasing recognition of the importance of transitions between these phases.

Q32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

- The College assessment of the skills of an SIMG are not complete until the SIMG process is finalised under NRAS. The College cannot offer advice on the qualifications of an SIMG until the SIMG assessment process is completed. The SIMG needs to have an appropriate employed role (using a skilled migrant visa) in order for both of these processes to be completed.

Q34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

- ANZCA suggests there should be consistency in the major steps in this process (application, interview, clinical practice and external assessment) but not in the intricacies within each of these steps. The assessment of competence of each profession should be different.
- The current guidelines for the assessment and subsequent granting of registration status for overseas-trained medical practitioners provide enough structure to build excellent processes without compromising patient safety or the quality of trained practitioners.

Q35 Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

- ANZCA suggests that there should be some allowance for exemptions in the assessment processes that lead to general registration for overseas trained practitioners. At present there are potential trainees from certain competent authorities who do not need to progress through the AMC pathway to gain general registration.
• ANZCA would like consideration to be given to an expansion of this assessment of an individual’s experience. In particular, SIMGs who have completed both an anaesthesia training program and twelve months of rotating internship should not be required to undertake further internship. In this case, an individualised assessment should be undertaken (for example, review of log books and curriculum).

• Evidence should be collected and consideration given to further development of the competent authority list.

Q36 Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

• ANZCA and FPM each have a Reconsideration, Review and Appeals process.
• ANZCA suggests that consideration be given as to whether the National Health Practitioner Ombudsman is the appropriate entity? For instance, once all College appeals processes are exhausted the National Health Practitioner Ombudsman could be considered.