College Submission

October 2024

Feedback to MBA Consultation on Draft Guidance on Professional Capabilities

Thank you for the opportunity for our College to provide advice to this consultation. We consider that the proposed guidance has significant implications for colleges and college quality standards.

As you will be aware, there is considerable change in the national policy space at this time and the College has not had the opportunity to undertake a detailed internal consultation of the proposed guidance. We note that the Medical Board was unable to extend the timeframe for submission of this advice but are hopeful that with the Council of Presidents of Medical Colleges (CPMC) we will be able to discuss these matters in more detail subsequent to the Committee's meeting in November.

Based on our initial review of the consultation documentation however we would like to make the following comments.

With reference to the following:

> *"As a matter of principle, the committee believes that the document describing the threshold professional capabilities required for practice in a profession (or other regulatory purposes) should be governed and owned by National Boards. This would not preclude other organisations from leading or being involved in the development of the capabilities, but it would mean that ownership and governance would reflect the regulatory functions of the capabilities.*
>
> *This would also be an important signal to all stakeholders about the importance of professional capabilities documents to the Boards regulatory role."*

We note the Ahpra Committees' interest as a matter of principle in the National Boards owning and governing the health professional minimum capability standards. We further note that it is the express purpose of the Committee to send a signal to all stakeholders of these document's significance to the Board's essential regulatory role.

If this approach is to be adopted, we see considerable risk that the health and medical profession's national minimum standards going forward will become decoupled from the holders of the expertise in knowing how and where best to set standards for each respective profession. We see potential for this to occur through ongoing legislated developments but also through the messaging that these documents explicitly aim to communicate to doctors and other health professionals, which is likely to be interpreted

as indicating that the nations' specialist registration authority views their own professions' standards as having been superseded.

As the College of Rural and Remote Medicine, our doctors work in some of the most unique and diverse work settings in the country and this has complex and nuanced implications for best practice care. A key distinction in these settings is that 'access to care' which may involve extensive travel, time delays and costs, is always a core consideration in formulating the quality and safety merits of any care standard. We see particular risk with that the proposed professional capabilities may see minimum thresholds for quality and safety appropriate for urban setting extended to rural and remote settings where they do not represent the best practice standards. Under the proposed arrangements, our College would, in that situation have reduced capacity and standing with which to uphold what we consider to be the appropriate standards amongst our members for the benefit of their communities.

For this reason, it is imperative that any formal documentation of the professional capabilities and their 'ownership' must include acknowledgement that the accredited medical and health professional bodies are the 'arbiters' of expertise in their respective disciplines and the "experts" in how best to set quality and safety standards within it.

1. Guidance on developing professional capabilities

For reasons as outlined above we consider that any guidance on developing capability standards should make explicit reference to the fact that the accredited professional colleges are recognised as the bearers of expertise in their respective professions.

2. Good Practice Professional Capabilities

Noting our concerns as detailed above, if threshold competencies including shared professional capabilities across health professions are to be developed and regulated by Ahpra and the National Boards the college would strongly recommend the following:

- That these capabilities relate to principles rather than content, are high level and outcomes based
- That documentation of these standards always includes explicit acknowledgement that the relevant accredited specialist college or professional organisation is the holder of expertise related to quality and safety in their respective disciplinary area
- That any shared professional capabilities are limited to a small number of generic service areas and avoid confusing, inhibiting or interfering with the detailed quality and safety guides, protocols, and standards that must be adhered to by each respective profession.

As outlined above, there is risk that these specific capabilities over time will come to be seen as the definitive clinical standards which will lead to standards not appropriately linked to the best evidence and knowledge of how these capabilities should sit within a disciplinary body of knowledge.

We note the suggestion that *patient assessment* be included among the shared capabilities and see this as an exemplar of an area of healthcare in which setting a single common standard would be problematic.

We would see common patient assessment standards as counterproductive to the goal of maintaining fit for purpose specifications for quality care. Patient assessment across all health professions and care settings will vary significantly not just in terms of the breadth and depth of professional knowledge that is drawn upon in undertaking the assessment, but also in terms of the differing priorities for appropriate assessment given different scenarios. For example, an audiologist undertaking a regular assessment, will have a different set of priorities to a paramedic in an emergency scenario, and a generalist will necessarily have a broader set of priorities to a consultant subspecialist. We see significant potential that setting common standards will create confusion, potentially establish conflicts in terms of practitioners' clinical priorities, and not reflect safe, high-quality patient care in every setting.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***healthy rural, remote and First Nations communities through excellence, social accountability, and innovation***.

The College works to *define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist profession*. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM has more than five thousand rural doctor members including one thousand registrars, living and working in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia and further afield. College members deliver expert front line medical care in a diverse range of settings including general practice, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as the Royal Flying Doctor Service and Australian Antarctic Division.

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and dreamings. We recognise these lands and waters have always been a place of teaching, learning, and healing.