27 April 2009

Ms Kim Sykes
Director
Service & Workforce Planning Branch
Department of Human Services
50 Lonsdale St
Melbourne VIC 3000

By email: workforce@dhs.vic.gov.au

Dear Ms Sykes

Health Workforce Competency Principles

The Branch was pleased to be invited to participate in the seminar program held on Monday 6 April to explore the issues associated with the Discussion Paper on Heath Workforce Competency Principles. We also appreciated the advice at that event that submissions could be made after the original deadline of 20 April.

Opportunities and Risks

Regrettably, we were disappointed to discover at the seminar that the proposed identification of shared competencies appears to be a solution in search of a problem, as presenters and delegates acknowledged that there is no identifiable purpose or function for such shared competencies.

In a system which now prides itself on being evidence based in all its key decisions, this "ready – fire – aim" approach was of concern.

Of course healthcare practitioners should be competent, and we also support interdisciplinary care, with clear triggers for patient referral across disciplines, but we reject the construction of graduate and specialist health professional education based **solely** upon a competency model. Many competency models follow the concepts of either academic competence or operational competence, both of which have been subject to criticism.

The ADAVB argues that these criterion-referenced models need to be replaced by a model that engages the **higher order competence**, performance and understanding which represent the best in professional practice.

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We also argue that in the assessment of undergraduates and the performance assessment of clinicians by employers, processes which address the higher order competencies must be used rather than merely 'objective assessment'.

As Huddle and Heudebert expressed it in their Viewpoint article: Taking Apart the Art: The Risk of Anatomizing Clinical Competence:

> *"Objective assessment may capture knowledge and skills that amount to the "building blocks" of competence, but it cannot elucidate or scrutinize higher level clinical competence. Higher-level competence involves sensitivity to clinical context and can be validly appraised only in such a context by fully competent clinical appraisers.*

Thomas S. Huddle, MD, PhD, and Gustavo R. Heudebert, MD. *Viewpoint: Taking Apart the Art: The Risk of Anatomizing Clinical Competence*. Acad Med. 2007; 82:1–1.

We note that the original information sheet about this project, published by the National Health Workforce Taskforce in May 2008, stated:

> *"If sufficient evidence indicates an appropriate level of service benefit for the health workforce, the project will build sectoral collaboration for a structured approach to this project will work in partnership with stakeholders to build an agreed methodology for implementing a core competency framework." (emphasis added)*

At the 6 April meeting with over 100 senior representatives present, no evidence was presented, and the facilitator even queried whether evidence had been used to arrive at the present system, as if we didn't need to do so to justify the imposition of shared competencies on health workers at all levels, in all fields and disciplines. In the absence of any evidence to support this measure, we argue that the project should not proceed, so that the energies of all concerned can be dedicated to the numerous other major change programs being promulgated by the State and Commonwealth Governments.

Numerous delegates pointed out that the majority of health services are delivered in primary health care (small business) settings and yet the dominant narrative in the discussion paper and the presentations was about institutional settings. To quote one of the delegates, 'The tail is once again wagging the dog'.

The proposed shared competency framework was essentially justified on cost grounds, because the cost of health service delivery is growing as a proportion of GDP, and efficiency measures are required to provide safe high quality care at lower cost.

Public sector 'managerialism' was all that we heard to justify an ill-defined exercise which could potentially end up costing more to implement. The identification of competencies and the encouragement for public sector employees to identify additional competencies through improving skills will lead to industrial claims based on work value – which would be entirely justified if more is asked of healthcare workers.

The irony is that those advocating the use of a shared competency framework as an efficiency measure were effectively saying it was a demand management tool, and so would be used to justify delivering less care at less expensive levels of skill and competence.

Prof Brian Jolly from Monash said that competencies are not cost drivers in the system and that these are more likely to relate to 'technology, desire and demographics'. Developing and implementing a competency framework will not address these issues.

Prof Brendan Murphy advocated the introduction of a third level assistant healthcare worker to relieve pressures on more qualified personnel, and suggested that the competency framework would be a means by which this could be achieved. Mr Carver, representing the National Health Workforce Taskforce, commented that he thought this suggestion was a 'furphy'.

Various comments were made that the project is not seeking to place individual health professions in jeopardy, and yet throughout the day people associated with the project made reference to 'professional silos' in a pejorative way. The Department must acknowledge that when Departmental representatives attack 'professional silos' they are perceived to be attacking professional standards and high quality care. This is only reinforced when they also focus on needing to reduce the cost of care, and promote the use of lower trained operatives as substitutes for professionals.

In our view **the bodies of knowledge accumulated by health professions having focussed attention within their fields and disciplines are the basis on which Australia is able to proudly state that it has one of the best health systems in the world.**

According to an Access Economics Report (20 January 2009, prepared for the Australian Association of Pathology Practices) on Health expenditure and outcomes:

"To assess Australia's overall performance in terms of outcomes relative to health system costs, OECD countries were ranked 1 to 30 for each data series – expenditure relative to GDP and per capita, public share, life expectancy, PYLL and health status. Two 'summary measures' were then calculated to assess:

- *the 'total' score, a metric measuring the 'bang for buck' from total health spending; and*
- *the 'public' score, a metric measuring the 'bang for buck' from public health spending.*

Using these metrics, Australia has the best performance from its public health expenditure of any OECD country, and the fourth highest performance from its total health expenditure (behind Japan, Spain and New Zealand). *"* (pp, 3-4) emphasis added

Two comments that appear in the National Health Workforce Taskforce Information Sheet of May 2008 regarding the proposed Core Competencies Framework for the Health Workforce, are highlighted for comment:

> *"Benefits to be derived from proposed outcomes:*
> *It is expected that development of a national perspective that identifies service benefits for the Australian health workforce will lead to policy recommendations about any proposed implementation of a framework, and its positive impact on health workforce supply." (p.2)*
>
> *"Identifying a core competency framework could provide a mechanism by which skills and knowledge can be recognised outside of the traditional silos of discrete professions. A core competency framework is a tool to describe the specific skills and knowledge a person has and could assist in facilitating staffing across profession and/or service stream that could result in encouragement of workforce flexibility and role redesign. It is not clear if evidence exists that such a framework will impact on reducing key shortages across the health workforce." (p.1)*

During the 6 April program an example was given by a panel member of an expected efficiency that would be offered by shared competencies, namely the avoidance of duplicated effort. In describing this benefit, it was explained that a healthcare worker who had a patient referred to them by another practitioner would not need to examine them again because this had already been done by the first practitioner, whose examination should be able to be trusted by the second one.

This shocking example failed to acknowledge that:

- the reason a practitioner refers a patient to another practitioner is usually because the needs of that patient are beyond their skill to address
- the referral is effectively saying the patient has presented with symptoms which are difficult to diagnose or treat. The second practitioner therefore has a **duty of care** to examine the patient again – this time with the benefit of their greater skill and insight, so that a more accurate diagnosis might be obtained and so that a suitable treatment plan can be developed and implemented
- the time elapsed between two examinations could result in significant differences in the diagnosis. A week or a month gap may give much greater clarity to signs or symptoms which were initially vague
- the Dental Practice Board of Victoria has made it clear to the ADAVB that where a patient is referred to another practitioner they have an obligation to complete their own examination and to form their own professional judgment about the patient's treatment needs
- failure to complete an independent examination diagnosis and treatment plan would expose the practitioner to a potential professional misconduct case for non-compliance with a regulatory obligation. Alternatively, in the event of treatment failure or alleged negligence, the absence of records of an examination and diagnostic observations would expose the practitioner to greater civil liability. The maxim goes – 'No records: no defence'.

From our observation, all of the examples given in the discussion paper and most of those mentioned at the meeting were content free, providing little indication of what a practitioner might actually do in the provision of healthcare. The delivery of clinical services is almost invisible in the framework, with a range of non-treatment oriented domains proposed, such as "use teamwork to deliver effective healthcare".

For any given competency in the proposed framework, we suggest that when the Dreyfus Model (novice to expert) is applied to the various qualification levels applicable across the span of healthcare, there would be at least 35 different levels of competency (shown as levels 1a to 7e in the chart below).

	Cert III	Cert IV	Diploma	Higher Diploma	3 year Degree	5 Year Degree	Post Grad Degree
Novice	1a	2a	3a	4a	5a	6a	7a
Advanced Beginner	1b	2b	3b	4b	5b	6b	7b
Competent	1c	2c	3c	4c	5c	6c	7c
Proficient	1d	2d	3d	4d	5d	6d	7d
Expert	1e	2e	3e	4e	5e	6e	7e

The competency framework therefore, does not so much identify shared competencies as it does agreed dimensions or domains, in which health care workers are expected to demonstrate different types and levels of competence.

Competency is a relative term. In dentistry there are various defined operatives, each of which may deal with certain common areas, but at different levels of complexity.

The degree of competency is both graded within each occupation and between occupations. An 'expert' dental therapist does not equate with an 'expert' dentist, nor would an 'expert' dentist equate with an 'expert' specialist dentist.

The competence of a beginning Certificate III dental assistant cannot reasonably be compared with that of an experienced oral and maxillofacial surgeon who has worked for 30 years in their specialty having completed eight years of post graduate study and been granted dual registration as a medical practitioner and specialist dentist. This example is restricted to the range within the dental discipline and does not even venture to compare the difference in levels of competency in the same domain between practitioners in unrelated fields e.g. pharmacist and dental technician. Shared competencies are therefore a nonsense at this level, and suggestions that workforce substitution can be advanced by identification of core competencies needs to be exposed for being irrational and impractical.

Defining Competency

The discussion paper purports to be about shared competency **principles**, so it is helpful before proceeding with a more detailed response to the questions posed, to consider what we mean by this term.

The senses in which we take the paper to be referring to principles are:

- a fundamental, primary, or general law or truth from which others are derived
- a personal or specific basis of conduct or management
- a guiding sense of the requirements and obligations of right conduct
- an adopted rule or method for application in action: a working principle for general use
- a rule or law exemplified in natural phenomena, the construction or operation of a machine, the working of a system, or the like
- the method of formation, operation, or procedure exhibited in a given case
- a determining characteristic of something; essential quality
- an originating or actuating agency or force

We found that the presentation of principles was poorly framed with isolated words used to suggest reference to a principle being more like a domain or realm in which a principle might be identified e.g. 'Law' or 'Equity'. If more appropriately framed principles were offered, then this approach might be supportable. Regrettably, the notions of a 'flexible workforce' and 'workforce substitution' overlay this with another agenda which undermines our willingness to support the initiative. The attempt to impose objective levels of assessment is therefore based on vague and subjective concepts.

The competencies sought are essentially accreditation standards for undergraduate and post graduate training courses. This means that they should desirably be addressed via the national accreditation program.

While the paper argues that it does not propose a generic healthcare worker or to "attempt to reduce the value of professional qualifications to the lowest common denominator", the proposed adoption of shared (or common) health workforce competency principles arises in the context of other moves to "reduce reliance on university trained professionals" and the promotion of 'workforce substitution'. It is not surprising therefore that the initiative is viewed with suspicion.

If Governments were really committed to reducing this reliance on university trained professionals, it would need to change the expectations of the public, media and courts about the safety and quality of care.

The Commonwealth Government would also need to review the recent decisions to establish four new dental schools (at Griffith, LaTrobe, Charles Sturt and James Cook universities). Why build four new university dental schools if you want to reduce your reliance on university trained professionals? One could cynically suggest – Why not move dental therapy and hygiene into the VET sector and close down dental schools instead?

The cost of maintaining a public sector workforce that can appear to attend to patient needs is a key driver of these reforms. As such, the political needs of Governments are unduly influencing the preparation of high quality graduates for the private sector, which represents 70%-80% of the market for oral health services.

When parties are in dispute about an issue, the customary approach to resolution is to step up to a level of principle at which agreement can be reached. To that extent, the strategy of seeking agreement on principles is well founded. Having established in principle agreement, exploration can then occur again at the next level down as actions consistent with agreed principles are proposed.

Whether this will result in anything meaningful in changed curricula and standards of care remains to be seen. **Our concern is that loss of focus on specific health**

disciplines by virtue of an emphasis on common content will result in a loss of quality outcomes.

The New Zealand Approach

Australia and New Zealand have mutual recognition arrangements for registration of health practitioners. Thus the approaches each country takes to health workforce education, training and regulation needs to take account of the other party. The NZ Health Practitioners Competence Assurance Act 2003 (HPCAA) "*provides a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession*".

The NZ Government says

> "*Having one legislative framework allows for consistent procedures and terminology across the professions now regulated by the Act. The principal purpose of protecting the health and safety of the public is emphasised and the Act includes mechanisms to ensure that practitioners are competent and fit to practise their professions for the duration of their professional lives.*"
> http://www.moh.govt.nz/hpca

The NZ approach to competence is therefore targeted at protecting public health and safety, and is integral to the registration and regulation of health professionals.

In the NZ Government's Review of the Health Practitioners Competence Assurance Act 2003, published earlier this year, it was noted:

> "*Responsible authorities are expected to set standards of* ***clinical competence*****,** ***cultural competence*** *and ethical conduct for their profession(s). Most have done so although some are still developing standards appropriate for their practitioners.*
>
> *Some standards for clinical competence are likely to be specific to the particular profession. Some, however, may be generic to all or several health professions. There is potential to make gains from authorities collaborating on the development of the latter group of standards. It is likely that even more of the standards in the cultural and ethical areas will be common across professions and could be improved by a collaborative approach.*" *(2009: p.23)*

This approach may be worth considering as a means by which to identify both shared and discipline specific competencies for Australian health professions.

The State Dental Boards and the Australian Dental Council have recently published a discussion paper regarding the development of National Dental Standards, and have now commenced preparation of advice to the yet-to-be-established Dental Board of Australia on this matter. They have also acknowledged that there will be a set of minimum safety standards produced by the Australian Commission on Safety and Quality in Health Care, applicable to all health professions, along with a range of other common standards as proposed by COAG. The competency agenda should focus on the capacity of health professionals to meet these shared and discipline specific standards?

Possible competency framework

A framework that can apply across all healthcare workers at all levels in each field will necessarily be very high level. The ability to do the work of each registered dental occupation involves training of from two years to 13 years depending on the field and level of specialisation. One size does not fit all, even within one field, much less across all health fields.

The common areas proposed include patient communication and awareness of regulatory obligations, which constitute only a very minor portion of the sum of knowledge skills and attitudes required to be an effective practitioner in each of the diverse fields.

A practitioner's 'flexibility' within a field requires the highest level of training across all detailed areas of content, rather than the most basic training. Therefore, the most flexible healthcare workers are not ancillary personnel they are professionals, because their training has prepared them to be adaptable to a wide range of circumstances and patient needs – including those they have not encountered before. This training allows them to respond without a textbook or a website to guide them along the path of an accepted clinical care protocol.

If the Department wants to frame a project around encouraging more Certificate III and Certificate IV graduates to undertake a degree program then we would support such a measure. We would **not** however, support an approach that sought to place everyone on the same broad scale.

ADAVB believes all that can be achieved by attempting to impose common course content is to bring the high quality practitioners down to the lowest level. Either that, or the principles identified in the framework are so generic that virtually any healthcare worker could meet them, regardless of their skill and training.

Healthcare workers undertake common activities and therefore require certain common skills, but the areas in which this can be demonstrated are not those on which the public relies for expert care. As the discussion paper rightly points out

"Rising consumer expectations are ... reinforcing this trend for evolving and more complex service delivery" (p.1)

Court cases demonstrate the ever growing demands for perfect outcomes from health services and the pressures on practitioners to be expert in their fields are therefore potent. Expertise is one of the outcomes of sustained practice and reflection within a defined field, and a generalist approach is antithetical to its development.

The ADAVB supports development of the health workforce to its highest level of competence, but the push for a shared competency approach will not achieve this. Various examples cited at 6 April seminar did not support the contention in the Discussion Paper that "a shared competency framework is not an attempt to limit individual healthcare professions in favour of generic healthcare workers" (p.3). The paper also argued that "Employing organisations can then be sharing or redistributing **generalist tasks** to focus instead on meeting the specialist requirements of their employee's roles".

What are these generalist tasks that can be so easily interchanged amongst all health professionals? There may be arguments about some hospital tasks being performed by professionals that could be delegated to assistants or ancillary personnel. If so, then focus attention on those areas and make a case for change. The argument that this approach is so beneficial that it must be extended to all health professions in all settings – including office based practice – has not been established.

The technical language employed by each of the health disciplines (e.g. physiotherapy, dentistry, podiatry) is significantly different, and would require induction exercises to enable basic common understanding. The healing of wounds in different regions of the body is vastly different, though due to the same mechanisms. How does a shared competency assist this?

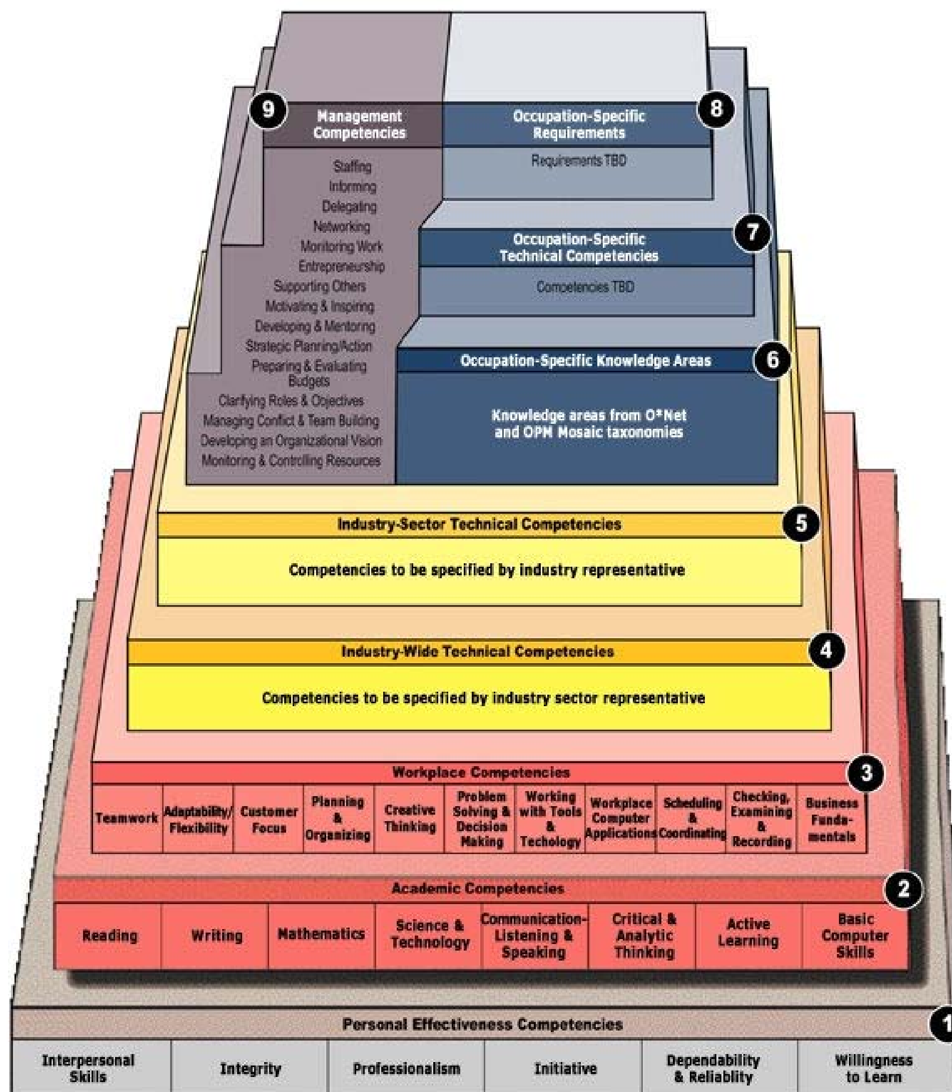
It may be possible to align the training programs for all healthcare workers so that common themes are addressed in relation to such matters as patient communication and consent. If this were the aim of the project then it would be both laudable and feasible. However, this would not result in nurses replacing dentists or dental hygienists substituting for nurse practitioners. Members who have worked extensively in hospital environments advise that where attempts have been made to replace ill dental staff members in public hospital units with competent nursing staff, this has lead to significant inefficiencies in practice, where the dentist is required to lose productive time in performing staff induction exercises.

Mr Carver commented at the 6 April seminar that the UK skills escalator approach was overly complex, and that Australia may not go "down that path". He also

argued that consistency in what is being taught would be a key purpose of a competency framework. Presumably he meant this to refer to certain principles rather than the details to be taught across all fields.

Table 4 in the Discussion Paper (p.13) suggests a range of core principles which might be sought in all healthcare worker training courses, and at this level we have no objection to the proposal. This agreement is heavily qualified however by the observation that these matters would form a very small part of the curriculum a dental student would need to cover.

The use of competency based learning and assessment originated in the US industrial sector following World War II. The US Department of Labor chart below describes the model by which occupational training is currently approached.



Source: http://www.careeronestop.org/COMPETENCYMODEL/pyramid.aspx

In this model, tiers 1-3 are foundational for all industries while tier 4 is applicable across an industry such as health services, and tier 5 is applicable across a sector, such as dentistry. Once the competency to be defined is occupation specific however, there ceases to be much commonality and the skill set required becomes more refined and therefore separate. Tiers 6-9 are therefore no longer concerned with common cross occupational competencies. If there is any commonality here it might be at a level of categorising knowledge and skills or utilising similar principles, e.g. related to research standards, patient-centred care or use of an evidence-based approach. The detailed content however will necessarily be highly specialised within VET training and higher education programs.

The widespread use of Problem-Based Learning (PBL) by higher education health training facilities reflects a recognition that **knowledge is 'context bound'**, and that meaning is attached to information by virtue of experience and reflection. While this approach is beneficial, recent examples have emerged in dentistry where PBL has lead to students not encountering practical training in sections of a basic discipline – e.g. surgery, prosthodontics – prior to graduation. This means that simplistic notions of healthcare workers undertaking general training and then seeking the specific answer to a problem when a situation demands it can only lead to lower quality care. In the case of health professional services, both the training to become a professional and the practice of the profession require subtle appreciation of context. Such an appreciation is **emergent** rather than fixed, and is not amenable to the central issuance of a guideline which is 'carved in stone'.

The competency debate has been extensive over many years and a simplified outline of the major forces at work within it suggests that the approaches can be described as:

- Instrumental / Outcomes based
- Knowing in action / Reflective; and
- Integrated

These approaches are illustrated by reference to some examples over the following pages.

The Constable and McCormick Report (1987) suggested that the skill base within UK organisations could no longer keep pace with the then developing business climate. In response, the Management Charter Initiative (MCI) sought to create a standard model where competence is recognised in the form of job-specific <u>outcomes</u>. Thus, competence is judged on performance of an individual in a specific job role. The competences required in each job role are defined through means of a functional analysis - a top-down process resulting in four levels of description:

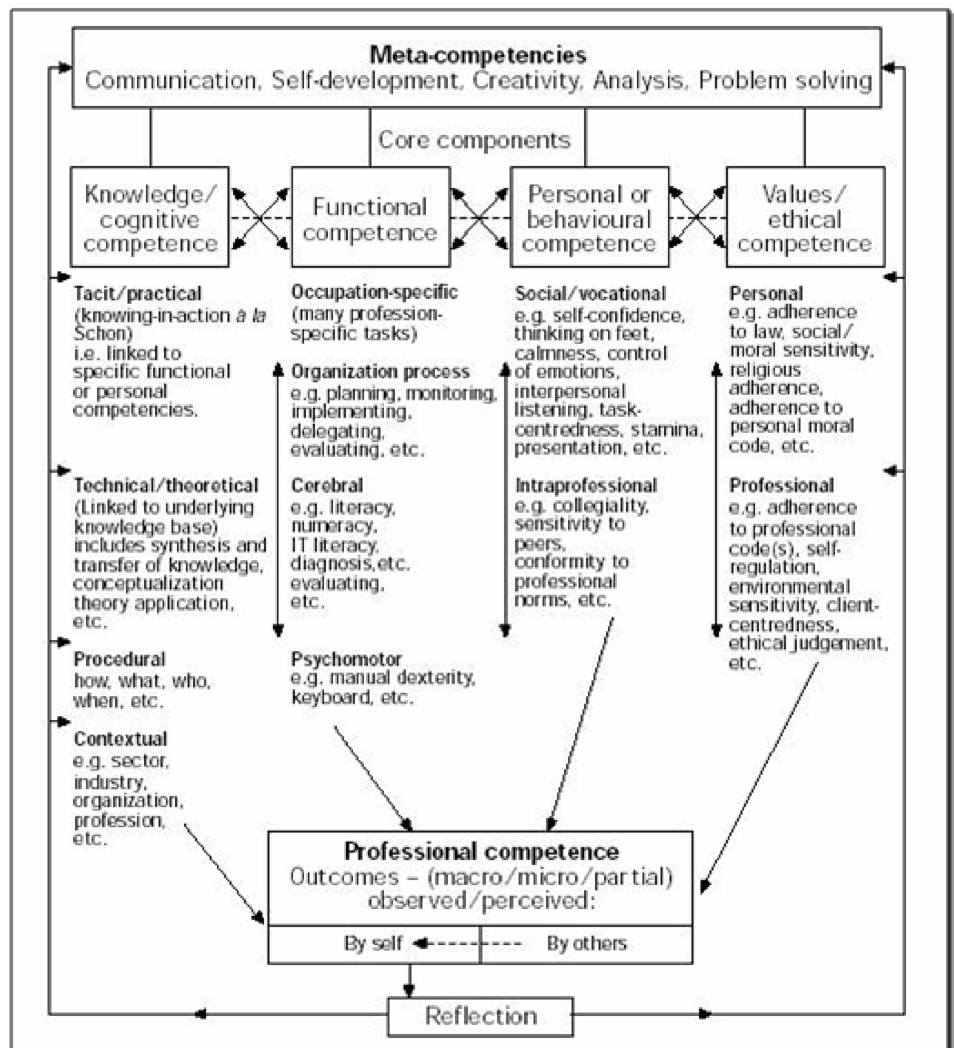
* Key purpose
* Key role
* Units of competence
* Elements of competence

As in the US precedents on which the UK system was based, elements were broken down into performance criteria, which describe the characteristics of competent performance, and range statements, which specify the range of situations or contexts in which the competence should be displayed.

In his seminal work "The Reflective Practitioner", Schon (1983) sought to define the nature of professional practice. He challenged the belief that professionals solve problems by simply applying specialist or scientific knowledge. Instead, he offered a new epistemology of professional practice of 'knowing-in-action' - a form of acquired tacit knowledge - and 'reflection' - the ability to learn through and within practice. Schon argued that reflection (both reflection in action and reflection about action) is vital to the process professionals go through in reframing and resolving day-to-day problems that are not answered by the simple application of scientific or technical principles.

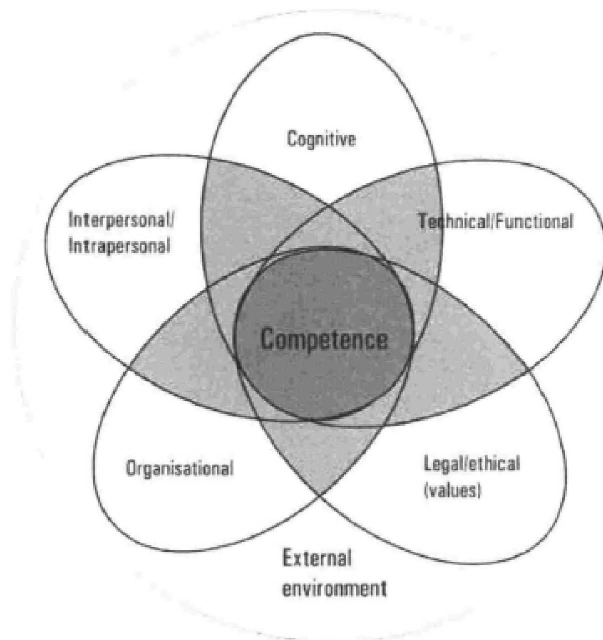
Cheetham and Chivers (1996) describe a model of competence that draws together the apparently disparate views of competence - the 'outcomes' approach and the 'reflective practitioner'(Schon, 1983, Schon, 1987) approach.

Their focus was to determine how professionals maintain and develop their professionalism. In drawing together their more integrated model, they consider the key influences of different approaches and writers.



The core components of the model are: Knowledge/cognitive competence, Functional competence, Personal or behavioural competence and Values/ethical competence with overarching meta-competencies include communication, self-development, creativity, analysis and problem-solving. Reflection in and about action(Schon, 1983) surround the model, thereby bringing the outcomes and reflective practitioner approaches together in one model, as illustrated in the chart above.

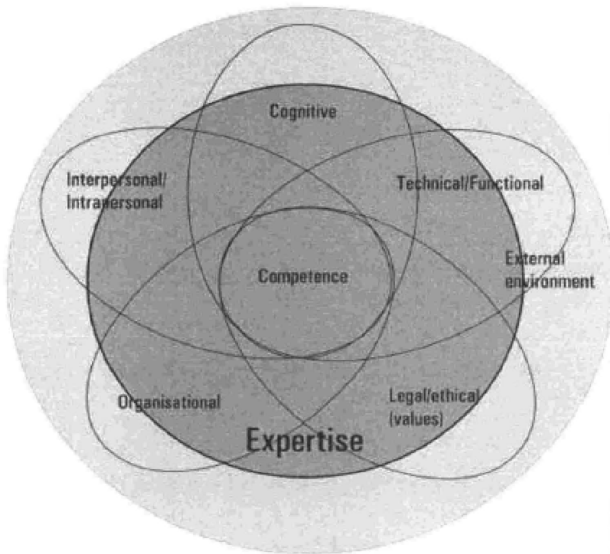
Cheetham and Chivers' model of professional competence is useful in bringing the concept of individual competence to bear on the competence of the organisation in a non-manufacturing context, but it still falls short of providing a useful model to link an individual's behaviour with the business results of an organisation across industries – say in the form of a generic model.



Dr Amanda Torr (PhD) in her 2005 thesis 'Professional Competence - Complexity, Concepts and Characteristics: A Case Study of New Zealand Pharmacy', offers a more refined and integrated model which we suggest would be a useful alternative to the models explored in the discussion paper. She states:

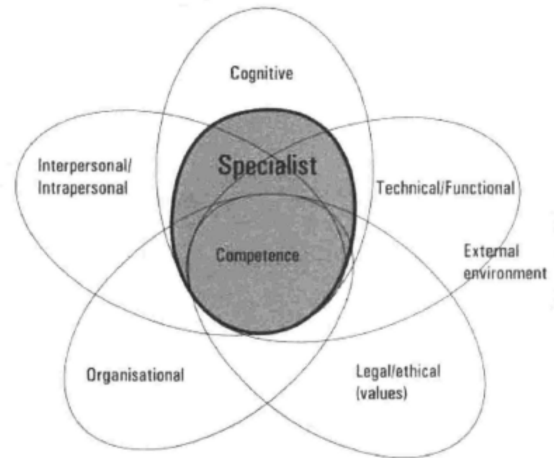
"The core construct of this model is that professional competence and expertise are accounted for by the ability of the practitioner to integrate the knowledge skills and attributes associated with these five "domains of competence": professional knowledge and cognitive skills, intra and interpersonal skills, technical skills, legal and ethical behaviour, and organisational skills." (p.151)

"In the model, expertise is accounted for by the degree of overlap between the domains of competence. In expert performance there is a larger and deeper degree of overlap in the domains than is seen with competent performance. In demonstrating this expertise, an expert performer is able to integrate across all the domains of competence at this higher, more comprehensive level." (p. 159)



"… specialist performance is different from expert performance. While experts integrate all the domains of competence at a higher level, specialist performance is characterised by a high capability in only one or two of the domains. Typically quoted in the interviews was the statement that these people had specialised knowledge in an area and could apply that to their practice. For example: They have specialised in a particular field of medicine - have a depth of knowledge in a specific area of specialisation."

"This suggests that if the overlap between the domains were mapped for a specialist performer, there would be a misalignment seen … For example, a specialist may have a great deal of clinical knowledge, but may not necessarily have the intra- or interpersonal skills to use it in a practice context. Such a practitioner would be a specialist in providing medicine information. " (p. 160-161)



Dental competencies

The field of dentistry is sufficiently complex in its own right that internationally it has identified 10 major specialties and three ancillary providers (dental therapists, dental hygienists and dental prosthetists).

The chart on the next page offers a simplified conceptualisation of the way general practitioners cover all aspects of dentistry, while specialists deal with complex matters within their fields, and ancillaries provided basic services in a subset of treatment areas. Each operative level has its own range of competencies from beginner to expert. General practitioner dentists act as care coordinators, monitoring the overall oral health of their patients, referring complex matters to specialists, while delegating simpler matters to ancillaries. **This model of care is efficient and designed in the interests of patient welfare.**

If ancillaries have their duties expanded too far they become the same as dentists and no efficiencies are offered to the community, so care is required to maintain the balance between these operatives.

Dental Treatment Fields and Levels

Specialist: Oral Medicine
Specialist: Periodontics
General Practice
Specialist: Endodontics
Specialist: Orthodontics
Ancillary Services
Beg. Competency Exp.
More complex Conditions and Treatments Simpler
Beginner Competency Expert
Partial fields only
Specialist: Oral and Maxillofacial Surgery
Specialist: Paedodontics
All dental fields
Specialist: Prosthodontics
Specialist: Oral Pathology

- General practitioner dentists are trained to diagnose and provide treatment across all fields, and to a quite complex level.
- Dental specialists do advanced training to deal with extremely complex work within a narrow field.
- Ancillary dental providers are trained to do basic diagnosis and provide basic treatment in only some aspects of dentistry.

Competency, expertise and understanding

In his essay, *Medical Education and the Tyranny of Competency*, medical educator Michael A Brooks sums up his concerns about the impact of competency based medical training on the quality of medical graduates:

> *"It should be clear that the competency mindset is one that views the physician as a technician, not as a professional. It engenders an educational system that is purely focused on vocational training. Physicians trained under such a scheme will have a large repertoire of prescribed behavioural skills but will not have the tools necessary to place these skills within a wider social, humanistic, or scientific context. They will have knowledge but will lack the practical wisdom that Aristotle called* ***phronesis****, the ability to know when and how to apply this knowledge to best help individual patients. The best surgeons, for example, are not those who have a high degree of technical skill—those who know how to do something—but rather those who know what to do, and when, and why, and especially, when not to do something. Vocational training is learning how to run a piece of machinery, but it does not make good doctors. In an era of growing dissatisfaction with our dehumanized, expensive, high-tech health care, we need to be educating real physicians, not training more "health care providers.""*

Perspectives in Biology and Medicine, volume 52, number 1 (winter 2009):90–102

He concludes by highlighting the emergent, holistic and dynamic nature of a health professional's knowledge and skill, and condemns the emphasis on competency checklists in the education of medical professionals:

> *"The competency framework is not compatible with what is known about the development of expertise. The medical professional does not follow a learned set of rules when diagnosing and treating patients. Rather, the professional decides whether to follow a rule and which one to follow (Tanenbaum 1999). The knowledge derived from medical research relates to statistical aggregates, but such knowledge must be applied using the practiced judgment of the professional in order to be useful. Physicians operate within the cloud of uncertainty that is each individual patient. A physician's personal experience, intuition, ability to reflect, interpret, and perceive are vital to the health of patients, and these qualities are even more vital to future advances and innovation in medical practice. A prescriptive, sclerotic model of education such as is proposed by the partisans of competency would be disastrous. The practice of medicine is not a checklist."*

Perspectives in Biology and Medicine, volume 52, number 1 (winter 2009):90–102

Dr Martin Talbot, the Director of Undergraduate Medical Education at Sheffield Teaching Hospitals, expresses similar concerns about the 'monocultural classifications' and 'limiting ideologies' of competence based models in his 2004 article *Monkey see, monkey do: a critique of the competency model in graduate medical education:*

> *"… competence is not the same as understanding. Understanding brings with it a critical edge and, in this era of evidence-based practice, a critical edge is a priceless tool for the professional. Competence demands a dichotomous resolution; understanding exists on many levels. Competence is a monolayer; understanding is many layered. Competence negates dialogue; understanding embraces it. Competence becomes stuck in an authoritarian certainty (and this begs the question of whose authority), but one's understanding may change tomorrow: that, surely, is the true nature of professional practice. Competence is value-neutral; medical practice is not. The immediate transfer of competence from one context of use to another involves considerable further learning. The leeway for this to occur under competency is very limited. Eraut concurs with many authors in cognitive psychology and process analysis who show that professional learning is an adaptive and heuristic process: skill-specific training only has a short-run effect unless it is backed up by longer lasting support."*

Source: MEDICAL EDUCATION 2004; Blackwell Publishing Ltd 38: 587–592

Commitment to improved efficiency

The ADAVB supports all sensible and sound measures by which efficiency can be improved. However, efficiency measures that might be relevant or desirable in a large institutional setting may have no relevance to those required in an office based private practice. Consequently, regulatory or other reform measures sought for the 20% of the system comprising the public sector should not dictate terms to the overwhelming majority of service providers, who are in the private sector.

Conclusion

The ADAVB argues that the only way a competency framework could work would be to apply an agreed set of high level domains to each of the health occupations. While all would encompass these domains in their curricula and training programs, individual roles within each field would still be subject to specialised qualifications in which the current (emerging) content in each field would be taught and assessed.

In the interests of achieving the widest possible agreement and maximum flexibility, the five "domains of competence" should be:

- professional knowledge and cognitive skills
- intra and interpersonal skills
- technical skills
- legal and ethical behaviour, and
- organisational skills

The opportunity cost involved in certification and the maintenance or improvement of the competencies also needs to be considered. A practitioner will only be contributing their skills to society when **not** involved in further study or attending to bureaucratic compliance issues.

Yours sincerely,

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