

Balancing Quality Agendas: Professional Accreditation and Quality Improvement in Health

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The unavoidable confluence of professional accreditation with other quality methods used in higher education raises problems for faculties of health (and perhaps others). These include preserving the benefits of potentially competing approaches to quality, managing workload, and sustaining staff engagement.

This paper outlines the conflicting purposes and incentives of the Deming-influenced quality policy of Monash University and the rigorous and compulsory accreditation of Australian (and New Zealand) medical schools conducted by the Australian Medical Council.

It offers a tentative solution to the problems of divergent quality agendas, confusing terminology, devolution, and informing quality choices. It is hoped that this solution will enhance sound quality practices in programs accredited by both competency- and process-oriented approaches.

Quality management terms not defined in this paper may be found in the AUQA Glossary, available at the Australian Universities Quality Agency Web site: <http://www.auqa.edu.au/tools/glossary/index.shtml>

1. Introduction

The Faculty of Medicine, Nursing and Health Sciences has recently begun a quality review of accredited courses. This presents the challenge of harmonising the Monash University quality review process with the diverse accreditation processes of external, professional bodies. As a Faculty Quality Management Group (QMG), we must enhance quality improvement—a central principle of the Monash approach to quality (Monash University, 2001, p. 2). To do this we must identify its proper relationship with professional accreditation, while protecting efficiency and staff goodwill to the university's quality agenda. This raises a range of change management problems.

One issue requiring urgent resolution is the 'fitness' of accreditation submission data to the 'purpose' of our quality process, as the recently reaccredited undergraduate medical degree (MBBS) is due for quality review this year. Although not all professional accreditations are rigorous, legitimate, independent, and/or voluntary (Harvey, 1996, pp. 3–4), the Australian Medical Council (AMC) accreditation addresses processes and curriculum content with great rigour and is compulsory for all Australian medical schools.

This paper draws on the experience of the initial AMC accreditation of the MBBS course (2001) to identify issues and suggest solutions that will serve the needs of the faculty without compromising the university's 'fitness for purpose' (Monash University, 2001, p. 1) agenda.

2. Context

Under Monash quality policy, 'if a course has external professional accreditation, faculties may choose to extend the external accreditation to include all the above terms of reference, or to incorporate results from external accreditation as part of their review process' (Monash University, 2001–2004, p. 3), where that accreditation is rigorous. The QMG has tried to align quality review with professional accreditation cycles, but there is increasing doubt that this will deliver sufficient improvement, efficiency or goodwill. We have not chosen to combine professional and university review processes because every professional accreditation is different, and negotiating a common agenda is too difficult. There is a basic conflict between the purposes of the two types of quality agenda.

3. Divergent Concerns?

Our Bachelor of Nutrition and Dietetics was professionally accredited in December 2003, and delivered its quality self-assessment in February 2004. The competency-based data required by the Dieticians Association of Australia (DAA) (1993) did not substantially address the faculty's quality terms of reference for courses (Faculty of Medicine, Nursing and Health Sciences Quality Management Group, 2003b). Aligning the timing brought few efficiency gains (M. Riley [Convenor, Bachelor of Nutrition & Dietetics, Faculty of Medicine, Nursing and Health Sciences, Monash University], personal communication, March 1, 2004). Dietetics embraced the opportunity to promote its new course to two divergent external panels, but the questions of staff we have trained to date focus largely on how to use professional accreditation data in their quality review submission (Faculty of Medicine, Nursing and Health Sciences Quality Management Group, 2002–2004b).

4. Reviewing Monash Courses for Quality, and the AMC Accreditation

The quality improvement agenda at Monash University differs from that of the AMC in their purpose and use of expertise. There are common features, but also significant conflicts. The Monash course review process—from which our faculty terms of reference are derived—aims to (a) 'assure quality of academic courses', and (b) 'to learn...in order to affect improvement'. It identifies itself as 'developmental' (Monash University, 2001–2004, p. 1). The purpose of the AMC accreditation committee is to: (a) develop standards and policy; (b) oversee medical school accreditation; and (c) encourage improvement in medical education 'to respond to evolving health needs and practices and educational and scientific developments' (AMC, 2002a, p. 43).

Professional accreditation is about power and control over the relevant industry (Harvey, 1996, p. 7; Keteku, 1999). It is outcome-focused (DAA, 1993; Nafalski, Dermott & Göl, 2001, p. 22; AMC, 2002b); because in the case of medicine, it is indirectly certifying the competency of graduates (Massaro, 2002). The AMC's stated goal is quality assurance of 'educational standards' (AMC, 2002a, p. 7) and its attitude to improvement is reactive. The Monash quality policy focuses on improvement, or quality 'time future', whereas the AMC insists on reaccrediting all curriculum changes, which encourages short-termism and fossilisation of the course.

The AMC uses accreditation panels of external clinical and other practitioners, lay people and some medical educators. Quality review of courses involves an internal self-review team drawn from the course management committee, and an external review panel comprising representatives of: the faculty, an Australian or overseas university, industry or employer group, students, and graduates (Monash University, 2001–2004, p. 6). These differences reflect the divergent purposes of quality improvement and professional accreditation.

5. Quality Terminologies

Language differences can disguise both compatibilities and conflicts between different quality agendas and methods (Giertz, 2001, pp. 2–4; Wright, 2001, p. 2). The AMC's use of the term 'quality assurance' with reference to standards seems to go beyond accepted definitions like 'checking...procedures are used and effective,' (AUQA, accessed 2004), which do reflect the Monash usage. The term 'standards', obfuscates the fact that the AMC does focus on process to assure adequate outcomes (C. Browne [Co-Chair, Medicine Course Management Committee, Faculty of Medicine, Nursing and Health Sciences, Monash University], personal communication, March 23, 2004). In presenting travelling roadshows on the university quality policy (Faculty of Medicine, Nursing and Health Sciences Quality Management Group, 2002–2004a; Faculty of Medicine, Nursing and Health Sciences Quality Management Group, 2002–2004b) we have noted that many teaching staff find the language of quality 'arcane and inscrutable', to quote Don Watson on public language (2003, p. 4). The pervasive jargon seems to undermine staff engagement, understanding (Swannell, 2002; Watson, 2003; M. Kutner [AMC panellist, Executive Secretary to the external review of the B. Behavioural Neuroscience, Faculty of Medicine, Nursing and Health Sciences, Monash University (February, 2004), and former Senior Project Officer,

Centre for Medical and Health Sciences, Faculty of Medicine, Nursing and Health Sciences, Monash University], personal communication, July 9, 2003) and commitment to quality. Accreditation jargon adds further confusion.

6. Horses for Courses

'[Monash] University [creates] its own quality agenda for its own unique situation,' (Monash University, 2001, p. 6). This 'fitness for purpose' approach suits the higher education environment (Ball, 1985, as cited in Giertz, 2001, p. 1) and meets the needs of a large, diverse, international university (Monash University, 1999–2004). The Course Management Committees of our non-accredited courses in health have found it appropriate and useful for their needs (N. Georgiou-Karistianis [Convenor, Bachelor of Behavioural Neuroscience, Faculty of Medicine, Nursing and Health Sciences, Monash University], personal communication, February 26, 2004).

Professional associations like the AMC offer a different service, i.e. 'certification by an external body that a programme or qualification is adequate for the purpose of a particular profession' (AUQA, accessed 2004). Some hospital-based staff familiar with this and more controlling approaches are resistant to the process-oriented and collegial quality improvement approach. Our concern is to indicate that different quality methods suit different contexts. The gap between quality improvement and professional accreditation can be significant.

7. Shaping the Submission

Influences on the AMC submission reflect the imperative to 'get it right the first time', rather than improving continuously. During AMC accreditation the medical school, the accreditation team, and the AMC committee (AMC, 2002a, pp. 61–2 & 73–4) frequently exchange information and comment, which informs the submission. By contrast, the external quality review panel is not appointed until the preparation of the self-assessment submission is well advanced (Monash University, 2003–2004). This panel may seek additional information, but there have been few requests so far. In keeping with the open enquiry approach (Monash University, 2001, p. 7), the external quality review panel has no opportunity to influence the submission it receives.

AMC accreditation for new medical courses takes about 30 months from preliminary discussion to the accreditation decision, whereas the quality course review process takes 12 months. The external quality panel validates the adequacy of the self-review submission and findings via interviews and tours during a two-day site visit. The AMC's summative site visit comprises five days of interviews and tours. Clearly, the output of the whole gruelling process should be used wherever appropriate.

The submission to the AMC is intended to document the course—analysis is the role of the AMC panel. This distinction does not eliminate bias from the submission. It would be naïve to present a submission that did not cast the course in the best possible light. Key writers of the new MBBS curriculum acknowledge some developmental advantages in the AMC process, but characterise it overall as a high stakes policing action that has the potential for highly intrusive consequences (C. Browne, personal communication, March 23, 2004) which may include senior personnel changes, or significant intervention by the AMC.

By contrast, a Monash quality self-review is a critical analysis that evaluates the course's 'directions, progress, achievements, strengths...areas for development and improvement and means [to achieve] these' (Monash University, 2001–2004, p. 5). The QMG encourages course staff to make commendations and recommendations in a collegial and collaborative spirit. Finding a problem is taken as evidence that self-assessment is working (Faculty of Medicine, Nursing and Health Sciences Quality Management Group, 2003a). The process provides an opportunity to safely escalate problems that the course management team cannot resolve alone.

Although less divergent from the Monash quality review process than the dietetics example, the AMC emphasises different priorities. Unique among these are health care industry concerns and issues of university management, student welfare, course content and teaching (AMC, 2002a, pp. 16–50 *passim*). Issues unique to the faculty's quality terms of reference are largely academic and management concerns such as alignment with university directions, course monitoring, student recruitment and financial management.

8. Managing Multiple Agendas and Perspectives

Since the AMC and the Monash quality approach have different desired outcomes, it is not surprising that they generate perverse incentives. Faculties of health sit at the confluence of the multiple, unavoidable and conflicting quality agendas of the higher education sector, the profession(s), and the government, which emphasise—in different measure—academic excellence, workforce suitability and financial accountability.

The quality approaches that accompany these agendas function as 'lenses' through which a professionally accredited course may be viewed. To achieve quality improvement, a Monash self-review team must use these lenses to bring the course into focus without too much distortion (Giertz, 2001, p. 6; Wright, 2001, p. 2). This is best achieved through an understanding of the distinctive nature of each 'lens'.

9. Devolution

At Monash, quality is the responsibility of all staff (Monash University, 2001, p. 6). The devolved approach is challenging to implement because many of our staff believe quality to entail a single goal or approach. Currently, the QMG advises staff that quality means 'quality improvement and fitness for purpose'. Other beliefs we have encountered include that professional accreditation *is* quality, or that quality is intrinsic.

Each of these views is common in some higher education circles (Wright, 2001, p. 2; Giertz, 2001, pp. 2–3). Harvey (1996, p. 1) highlights that in Europe accreditation is being used inappropriately, and that its political nature is not well-understood. Many of our staff members are not aware of debates about quality approaches for higher education, nor of other views, nor the ideologies that inform them (Giertz, 2001, p. 2). There is little of the 'open, public discourse' advocated by Wright (2001, p. 1). Devolution to staff who hold differing views of quality is further complicated by the fact that academics can and will veto any decision they are asked to implement (P. Darvall, farewell speech on the occasion of his retirement at the Monash University Club, Clayton, August 27, 2003).

The potential for the combination of professional accreditation and quality review to increase workload is a serious issue, as are the unacknowledged, competing philosophies of quality. Taken together, these factors threaten goodwill and good practice. They present the worrying possibility that professional accreditation data could assume a disproportionate influence on quality reviews in our faculty. To adapt Lee Harvey's point about measures, (1996, p. 29) convenient data can be seized on because they are available, rather than because they help to elucidate questions of quality. The contradictions outlined above underscore the undesirability of this outcome.

10. Informing Quality Choices

The QMG must equip staff to make appropriate choices in conducting quality review. We suggest that the three common beliefs about quality described above may all, in combination, contribute to sound quality practices (Giertz, 2001, p. 5) that will suit our faculty. We propose to address quality improvement and efficiency and maintain staff goodwill towards the quality agenda by stimulating discussion about quality issues and methods in our training of course management committees. We hope to increase the sophistication of staff understandings about quality by acknowledging more opinions within and outside the faculty, elucidating the profusion of terms, and explaining our policy choices about quality.

It is vital to the success of devolution to acknowledge the legitimacy of 'intrinsic quality', '[academic] excellence' (Giertz, 2001, p. 3), or what Wright (2001, p. 2) calls 'the standards already implicit in good academic practice.' We will promote organisational learning (Monash University, 2001, p. 6) by enlisting the support of all staff and acknowledging dissenting views, to give everyone some ownership of the decisions made (Senge et al., 1994–2000, p. 300).

To overcome the inherent bias of heavy reliance on accreditation submission data, we propose to promote triangulation. Staff will be encouraged to interrogate the data they present, to ensure that it addresses the *spirit* as well as the letter of the quality terms of reference. Although insisting on multiple methods may not address the workload problem, other advantages will accrue to staff, as follows:

- This approach will provide better information, allowing staff to better identify appropriate improvements for their courses. It will increase efficient use of staff time by highlighting the most important issues for action. Quality improvement will be well served by this approach.
- Staff participation and experience in quality review will be formally recognised. This acknowledgement should help mitigate the workload issue.

11. Conclusion

Our experience with accreditation bears out that of other higher education systems. We will pilot this solution with the MBBS in 2004. We expect it to be applicable also to less rigorously accredited programmes, and to more competency-based accreditation processes. Any adjustments for particular programmes are expected to be minor.

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AUQA—*see* Australian Universities Quality Agency.

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