AHPRA – Feedback on supervised practice framework

1- Firstly, I admit I am involved with this issue so my response reflects my practical bitter experience with this matter.

2- In deciding how to improve the process of supervision, the obvious response to the question of why a practitioner needs to be supervised is that it is necessary for the safety of patients, but I wonder:

A- Is this safety achievable through supervision?

B- Is supervised practice necessary?

C- Is it practically possible to get supervision?

The answers to these questions are explained below.

3- A practitioner whom AHPRA designates can work only under supervision will fall into one of following categories.

A- A practitioner who is accused of misconduct because he is Involved with a matter(s) related to moral issues such as forgery, sex, illicit drug use etc. These practitioners will not benefit from such supervision.

B- A practitioner may be accused of a lack of knowledge. This is highly implausible for a senior practitioner with multiple approved basic qualifications and many postgraduate qualifications from all over the world as well as from Australia.

C- A practitioner may be accused of technical skills deficiency. If many decades of experience and work on thousands of patients was not enough to give somebody enough skill and experience, then extra one year would not give them that opportunity. And the argument against such a claim is even further strengthened if they received a good report while working in Australia at one of our great tertiary centers.

D- A practitioner may be accused of misconduct because he has unreasonably high morbidity and/or mortality rates. This can be the case if his morbidity or mortality figures are compared to other colleagues in a similar situation with similar practices in Australia. This comparison has never been done by AHPRA. Supervision of accused practitioners will not fix safety concerns about one third of the patients admitted to hospitals who end up with a complication(s), according to the Gratten institute report. In fact,

very few of those cases (and up to hospital discretion) were ever referred to AHPRA.

E- A practitioner may be accused of misconduct because he does not follow the best practice in his decision making. The best practice is defined as the practice that follows evidence based medicine. Currently, this is not how a practitioner is judged by AHPRA – instead, the judgment is based on the personal opinion of a randomly selected witness (es) to give their opinion – an approach which veers far from evidence based medicine. Even if one or more of the cases involved showed some error of judgment at some time, the lessons are learned and <u>supervision would not do anything more to help regarding patient safety</u>.

F- Finding a job under supervision is almost impossible, especially for senior practitioners. Furthermore, hospitals do not like giving jobs to someone under supervision as it carries a lot of legal responsibility. No practitioner like to supervise a colleague, for the same reasons. Even areas of need don't want somebody under supervision as they lack the resources to supervise these practitioners. In fact, some hospital itineraries state that they do not want anybody under supervision. <u>I wonder if AHPRA is aware of this.</u>

G- Essentially, what the mandatory supervision does is cut the practitioner off from practice. <u>This period of time spent away from clinical work is counter-productive as it has the opposite effect of making them safer</u>, if they were able to return to work. Ironically, AHPRA wants practitioners to keep their CPD up-to-date before going back to work – an impossible task. If you are out of work, you can indeed maintain your theoretical knowledge but you certainly cannot maintain practical skills without being involved in any clinical work. <u>I would like to know how AHPRA sees the requirement of supervision as being helpful in this case.</u>

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