**From**: Philip Richardson [redacted]
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**To**: medboardconsultation
**Subject**: Revalidation - Submission

Dear AHPRA Staff

I have read with interest the report and the methodology used and the proposed possible models have been involved in my own college in relation to revalidation at least 4 years ago well before the current interest and decisions to progress it. A weakness of the profession is its inability to be proactive to many contemporary issues whereby reactive action often results in poorly constructed solutions with minimal involvement from the membership who are required to comply with it and whom have the best understanding to the challenges and obstacles for a meaningful outcome.

I was very much aware of some of these challenges to change within my own college because of inflexible positions, a view that specialist in general should not need to prove competency on an ongoing basis and that the introduction of a scheme does not achieve its objective because it is quantitative not qualitative, is at the expense of service provision and does not capture impaired or under-performing clinicians.

While it is useful to look at models elsewhere how these are evaluated and can be evaluated in their effectiveness also exposes inherent weaknesses and there failure to identify and to achieve the objective under pinning the programs in my view, CPD and compliance with individual colleges programs, can provide a qualitative component to a model as long as there are mandatory clinical competency evaluating domains, there should be an emphasis on work based assessments.

I think it prudent to consider the medical education platform and curriculums that now form the basis for specialty programs, and any revalidation model must be aligned to the educational theory that has underpinned changes in most colleges in recent years. Whether revalidation is used as a generic tool for ongoing competency or to address re-entry into the workforce after an absence of clinical practice.

In understanding specialty training programs will allow for a seamless model which is familiar and less likely to have issues with implementation and for which structures and principles already exist.

Incorporation of other components outside the general jurisdiction of the colleges which sets the standard for its specialty guided by accreditation through AMC which allows oversight and critique of internal process and opportunity to evolve, other workplace tools may also have a role as eluded too – but this can be limited and subject institutional and potentially political factors. Never-the-less 360 MSF and a complaints register may provide only some insight to performance, and complaints in the work place often do not relate to individual performance which in itself maybe subject to workplace conditions. Also such complaints are not common and therefore would not provide significant or relevant information about competency and that a more robust model while incorporating this needs to have more defensible assessment tools if it is to have any validity and meet the needs of the various specialties. It is clear that while there will be generic components the sub parts will need to be specialty specific and carefully developed whether this is in the public or private domains.

I am yet to see clinically driven leadership in this area by clinically active, insightful members/registrants which in my opinion is essential, and that current communication on this important issue is poor and almost incidental.

Regards
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