



From the President

24 November 2016

Dr Joanne Katsoris
Executive Officer Medical
AHPRA
GPO Box 9958
Melbourne 3001
Via email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris

**Re: Consultation on options for revalidation in Australia
Submission by The Royal Australasian College of Physicians**

Thank you for the opportunity to comment on the Medical Board of Australia (MBA)'s Expert Advisory Group (EAG)'s proposed approach to revalidation in Australia.

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of more than 14,300 physicians – often referred to as medical specialists – and 6,500 trainees, across Australia and New Zealand. It represents more than 32 medical specialties including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. The College strives for excellence in health and medical care through lifelong learning, quality performance and advocacy.

Options for revalidation in Australia

The RACP broadly supports the EAG's proposed approach to revalidation in Australia.

Regarding specific questions, the RACP would like to make the following comments:

1. *Is the proposed integrated approach a reasonable way to improve the performance of all medical practitioners, reduce risk to the public, proactively identify and then support remediation of individual medical practitioners back to safe practice?*

The RACP considers that an integrated approach is appropriate, but notes that the two aims do not necessarily align easily and that the disparity between them introduces significant challenges in delivering this. If an integrated approach means both aims will be addressed through the same portfolio of activities (e.g. audit, formal feedback, peer review and reflection) relevant to each individual doctor, we would support the proposal in principle, subject to clarification of the range of activities or elements considered suitable and the way in which risk assessments will be derived from these. In particular, it will be important to ensure this process does not introduce a discriminatory effect for any particular group or groups such as older male practitioners.

In addition to integration of the two objectives, the RACP considers that the integration outlined in the second of the guiding principles ("...integrated with-and draw on-existing systems.....") will be critical to successful implementation of a revalidation framework. In

particular, the RACP considers that integration of performance improvement processes into normal work processes as much as possible will be essential.

2. *Are there other approaches that could feasibly achieve these aims?*

Given the diverse settings and governance arrangements for medical practice in Australia and the frequency with which practitioners' scopes of practice evolve over time, other models for revalidation frameworks seem either inappropriate or unworkable. The RACP agrees that a model based on an augmented form of continuing professional development (CPD) would be most suitable for the intended purpose.

3. *What are the barriers to implementation and gaps that will need to be addressed for the proposed approach?*

There are numerous potential barriers to implementation which will need to be overcome. These include general cynicism amongst doctors regarding the underlying intent of the program, a tendency for doctors to focus on traditional continuing education rather than professional development (especially CPD which examines workplace performance), concern about the potential that Colleges might be expected to assume regulatory functions, lack of clarity about assessment processes to detect actual or potential poor performance and lack, for now at least, of clarity on the assignment of responsibility for remediation processes where these are needed. Practitioner resistance to both concept and process will become reality if the early experience of participants is unsatisfactory. The RACP considers that to reduce the likelihood of this happening, new "strengthened CPD" elements should be introduced into existing CPD programs and their use encouraged and assisted well before the introduction of any formal requirements for their use.

The RACP believes that there are a number of key gaps to be filled at this stage. Amongst other things, these include repeated articulation of the community's expectations regarding revalidation of doctors, publication of a clear evidence base supporting the likely effectiveness of a revalidation framework (acknowledging that much of this is addressed in the Interim Report), delineation of the elements of the framework at the level of individual practitioners, and clarification of roles and responsibilities in detection of poor performance and in remediation.

Further consideration needs to be given to how factors that motivate doctors' engagement in CPD might be identified and applied in this process. Consideration needs to be given to strategies to enhance practitioner involvement, for example, using opinion leaders to present examples of enhanced performance and examples of feasibility and practicality, and to ensure that those engaged in crucial roles in the process have the requisite skills. In order to maximise the support of the profession, these activities may be best undertaken under the auspices of the Colleges.

The financial cost of revalidation and associated loss of productivity associated with compliance are also potential barriers to implementation. Any new program will need to be integrated into daily activities as much as possible and health services will need to allocate adequate time and resources for this.

Our response to Q23 describes the misunderstanding which often exists around the relationship between a future revalidation framework, privileged quality activities in the workplace, the regulator's process for handling complaints and mandatory reporting obligations. An unambiguously clear and readily accessible resource which addresses this would be very welcome.

4. *Do you agree with the guiding principles? Are there other guiding principles that should be added? Are there guiding principles that are not relevant?*

The RACP supports these guiding principles strongly and suggests that they be incorporated into any post-implementation evaluation program as performance indicators. The three

principles sit well together, are sufficient as a group and address areas of major concern for practitioners. As noted in the response to Q3, the early experience of practitioners will be critical to acceptance, and participants will be expecting strong evidence of adherence to the guiding principles. Conversely, practitioners are likely to see the three principles as a minimal starting point for any changes to their professional regulation process.

5. *How can evidence-based strengthened CPD be achieved?*

There is existing evidence to support the increased value, validity and effectiveness of activities which might be considered part of “strengthened CPD”. The RACP notes that the introduction of the legislated recertification framework in New Zealand requires Colleges to develop CPD elements on practice and peer review, clinical audit and performance feedback, and expects that the MCNZ will progressively increase the requirement that Colleges include these activities in their CPD programs. The timeframe for introduction of these elements has permitted Colleges to develop and test model elements with Fellows and to examine factors such as relevance, practicality, scalability and sustainability.

As noted above, making these activities available to College Fellows as optional or voluntary activities at first, well in advance of any formal program, and supporting their use through education will be likely to reduce the resistance which might accompany a more abrupt introduction without “socialisation”. This approach would help identify a group of practitioners as “early adopters” able to advise colleagues and provide unofficial leadership.

6. *Who should be involved in strengthening CPD and what are their roles?*

The current Australasian accreditation framework for specialist medical education programs covers CPD programs for registered practitioners as well as the primary training programs. For now at least in Australasia, the only AMC accredited bodies delivering specialist medical education are the Colleges. The RACP holds the firm view that Colleges should retain responsibility for further development of their CPD programs to deliver the “strengthened CPD” and that they should have control over the processes implemented provided that the final program can deliver the required outcomes. A strategic evolution of existing CPD programs will offer the best chance of achieving an optimal balance between discipline specificity and overall outcomes. This approach is predicated on Colleges ensuring that any “strengthened CPD” program is based not only on contemporary post-graduate medical education best practice, but reflects input from key stakeholders including representatives of patients and the community.

The RACP’s Fellowship covers a very broad group of medical specialties and the practice patterns of other specialist groups add even more variety to the overall picture. In order for any ultimate revalidation framework to meet the requirements of the second and third guiding principles, it will be essential that it be embedded in the CPD programs of the specialist Colleges. The key corollary of this is of course that the final models will both differ from each other to some extent and will also need to offer a sufficient range of elements to accommodate diverse groups of Fellows in Colleges such as the RACP. For example, many procedural groups already submit data on procedures and outcomes to national registries and databases which could be used to monitor variations in standards or departure from agreed norms. On the other hand, non-procedural practitioners are less likely to participate in these systems and will need to use alternative tools to monitor outcomes. This does not however preclude the development of a generic framework applicable to all doctors, particularly in domains of practice other than discipline specific knowledge, expertise and practice.

The RACP acknowledges that there is a significant group of practitioners in Australia who are not members of a specialist College and whose needs would not necessarily be met from elsewhere. The model in place in New Zealand provides a possible option here as well, for a proportion of these practitioners at least. In that setting, some clinicians with non-

vocational registration are able to access the CPD program of the specialist College which best matches the scope of their clinical practice. There should be no barriers to providing access for Australian practitioners in an analogous situation if appropriate. (The NZ model also offers a separate program for doctors who do not or cannot access the CPD program of a specialist College. This program is provided by an organisation contracted to MCNZ and is discussed further in our response to Q25.)

7. *Are there any unintended consequences of this approach?*

The RACP is particularly concerned that two specific unintended consequences might arise in the design and implementation of a revalidation framework. First, we have watched the UK revalidation program with interest since its introduction and have noted that the high level of regulation and the prescriptive nature of the program have imposed considerable demands on participants. The extent to which this has affected doctors at the level of their clinical service has become increasingly evident through the first post-implementation review. In addition, disconcerting inconsistencies in the training and practices of the Responsible Officers have also been identified by the separate review of that part of the revalidation program. The RACP would not support a framework of such complexity (especially in terms of the time demands required in compliance) and considers that any unintended drift away from the guiding principles would undermine trust and support very substantially.

Second, the interim report and discussion paper articulate important principles for a new framework but seek suggestions rather than propose a specific model for the way in which actual or potential poor performance will be monitored and reported. There is inevitably a link between performance assessment and the Regulator, and whilst the RACP supports a model in which there is a graduated approach to performance monitoring and remediation, we are anxious to avoid becoming a de-facto regulator or a formal agent of the MBA. It is not yet clear how this can be negotiated although the College is strongly committed to further collaboration, especially with employers and health care facilities to help resolve the question.

Other potential unintended consequences have also been identified. For example, experience in Canada suggests that programs which monitor doctor performance will identify approximately 5% of doctors performing just above acceptable standards. Remediation for these practitioners will require allocation of additional resources, raising questions of how this would be funded and how the remediation will be coordinated and delivered.

Prior to introduction of the UK's Revalidation program, some doctors indicated that they would retire earlier than they had initially planned rather than participate in the program. The RACP notes that the current review of the Revalidation suggests that this was largely an empty threat and that early retirements have not occurred to any significant extent. Despite this, the RACP notes that similar sentiments have been expressed in Australia in response to the release of the MBA's Interim Report. Notwithstanding the possibility that some practitioners opting for early retirement might have foreseen difficulties in meeting the requirements of a revalidation program, any unbalanced loss of experienced practitioners from the workforce would be a significant unintended consequence.

8. *How can we collaborate with employers and other agencies involved in systems which support and assure safe practice to minimise duplication of effort?*

The RACP notes that medical staff employed in all public hospital systems in Australia are (at least notionally) required to participate in a prescribed performance monitoring program. The underlying principles of all of these State- or Territory-wide programs are similar and are broadly consistent with the aims of a revalidation program and when implemented properly, they address at least some of the objectives outlined in the interim report. Following discussions held with health system leaders in New Zealand and some initial pilot testing of

a practice review program in the Auckland area, we believe that integration with employer-based programs is both feasible and desirable.

Similarly, all accredited private health facilities in Australia will have functional clinical governance systems established, with clinical performance and outcome data available for individual practitioners. Although different from the State and Territory performance programs, data from these processes could also be used by practitioners to demonstrate performance and to document outcomes to some extent at least.

Although there are potential areas of conflict and challenges in developing a single integrated process that meets requirements of an employer or private care facility, the regulator and the profession (College-based CPD), our initial experience in NZ suggests that the advantages of “doing it once and doing it right” seem to outweigh the potential disadvantages.. The key to this approach will be agreement between stakeholders on the smallest possible set of elements which still provides the data required and which also meets the needs of all of those stakeholders.

9. *Is each of these principles relevant and appropriate?*

The RACP considers that the 10 principles or characteristics of high quality CPD programs are all relevant and appropriate. It is worth noting that the term “self-reflection” is often poorly understood and not well addressed by participants in the RACP’s MyCPD program. Conversely, the idea that a CPD program should focus on outcomes the individual seeks to achieve implies that the practitioner engages in reflective practice, at least to the extent that there has been an assessment of development needs, and a “discussion” that has led to the development of an agreed professional development plan. This assessment and “discussion” may well have been an entirely private and undocumented event. It might therefore be reasonable to consider condensing the third and fifth principles together to provide a practical context for the use of reflection.

10. *Are there other guiding principles for CPD that should be added?*

We do not consider that additional guiding principles for CPD are needed, but note that there is no specific reference to assessment or appraisal of performance in the principles. Although an element of assessment is implied in a number of the principles, it may be appropriate to change the wording of the principles slightly so that it is quite clear that formal documentation of practitioner performance and clinical outcomes is involved as well as the recording of more traditional activity undertaken.

11. *What is your view on the proposed model for strengthening CPD that includes a combination of performance review, outcome measurement and validated educational activities?*

The RACP supports the proposed three streams framework for CPD. Our own surveys indicate that there is a strong tendency for practitioners to prefer traditional CME activities over those which review performance or measure outcomes. (These traditional CME activities are well understood as part of current CPD programs and are more easily documented.) Shifting the perspective of Fellows towards activities which assess performance and document outcomes will be a key challenge during implementation of any program of the type proposed. We note also that the context of medical practice frequently involves work in teams rather than as individuals and support the perspective addressed briefly in the interim report that assessment of team performance and outcome data should be considered an integral part of relevant activity.

The RACP notes that it will be important that effective information systems are available to support audits and other activities which document patient outcomes regardless of the practice setting. The College’s experience so far has shown that much of the data collected by larger health systems is inaccessible to individual practitioners (usually because

aggregation of the data prevents analysis of individual performance) or is inappropriate for the purpose (for instance because the data focus on financial rather than clinical performance).

12. *What are the implications for specialist college programs if medical practitioners were required to undertake CPD that is a combination of performance review, outcome measurement and validated educational activities?*

As noted above, specialist college programs deployed in New Zealand are already moving steadily to introduce CPD elements which incorporate performance review and outcome measurement to allow NZ Fellows to meet their recertification requirements. As a result, these concepts have already been incorporated into the CPD framework for a significant portion of the RACP's Fellows. The RACP considers that the similarities between our two systems are sufficiently strong that the tools which have been developed in New Zealand will be broadly applicable in Australia as well. It is worth noting however that even the early development of appropriate tools for RACP Fellows has required a significant commitment of resources.

Apart from the logistic and practical issues of ensuring that systems are as consistent as possible on both sides of the Tasman, the RACP notes that shifting the understanding of Fellows and their choice of CPD activities will be the main challenge. The key issue however will be the development and support of appropriate CPD tools which will permit valid and efficient review of performance and measurement of outcomes in programs which are sustainable and which can be used by practitioners in very diverse practice settings, with diverse scopes of practice and with a variety of personal circumstances.

We know from surveys of Fellows and the RACP's random audit program that Fellows often undertake considerably more CPD activity than they record, and that the reported activities tend to be those which are easiest to document. Newer elements which document audit, performance and outcome measures generally involve more complex documentation and it will be very important that an appropriate balance (consistent with the three guiding principles) be maintained in future iterations of CPD programs.

13. *What are the implications for medical practitioners undertaking self-directed programs if medical practitioners were required to undertake CPD that is a combination of performance review, outcome measurement and validated educational activities?*

At the level of the individual practitioner, shifting CPD requirements to include performance review and measurement of outcomes will involve a major revision of the understanding of CPD. As noted above, we are aware that many College Fellows report a very strong preponderance of traditional CME activities in their annual returns. This effect is likely to be even stronger amongst doctors following an independent self-directed CPD program. Shifting this perspective will require a considerable effort in education, presumably led by Colleges as well as ready access to templates and tools which will allow practitioners to comply. Again, the independent practitioners will not necessarily have access to the education or the templates and tools. As noted above, the RACP considers that making these available for Fellows as optional activities well before the formal requirements are introduced will be essential to acceptance.

Any practitioner undertaking a self-directed program of CPD will face a significant challenge accessing templates for audits and other outcome measurements, other tools for demonstrating performance, and in particular, valid MSF tools. Although this would not be insurmountable, this group of practitioners may find it more efficient to re-join the CPD programs of their respective specialty Colleges. This shift could be accommodated without difficulty by our existing CPD system.

14. *Is it a reasonable approach to work to better understand the factors that increase medical practitioners risk of performing poorly so that efforts can be focussed on this group of doctors?*

The RACP agrees that development of a better understanding of factors involved in poor performance of doctors is very important. We note however that this is a broad area which will require significant investment especially if a detailed understanding of specific factors in Australia is sought. Further, the College considers that this area needs to be investigated with the same scientific rigour that we would apply to any other “risk factor” analysis.

15. *Do you have any feedback on these risk factors identified in the evidence? Do you know of other risk factors that are relevant? Are you aware of combinations of risk factors that can identify medical practitioners at risk of performing poorly?*

The risk factors outlined in the discussion document are reasonably comprehensive. Papadakis et al (N Engl J Med 2005; 353:2673-2682) and Tamblyn et al (JAMA. 2007; 298:993-1001) also offer perspectives on early predictors of poor performance. These observations show that unprofessional behaviour in medical school and poor performance on national licensing examinations are also associated with an increased likelihood of future complaints and poor performance. The extent to which these issues can be factored into a revalidation framework administered during independent practice remains unclear, but adding them to the list of known factors seems reasonable at this stage.

The RACP notes that even if features pointing to a higher likelihood of poor performance are identified in a practitioner's profile, the absolute risk is still relatively low, and certainly much lower than the likelihood of future poor performance once already documented. Whilst acknowledging that international systems, especially those in place in most Canadian Provinces, do use a risk identification and stratification algorithm, the RACP considers that approaches to practitioners “at risk” of poor performance need to be distinct from those for practitioners with defined performance concerns.

16. *Who can play a part in the identification of at risk and poorly performing doctors to strengthen early identification? How would this occur?*

Medical practice is conducted in multiple settings in Australia, ranging from solo regional practice to full time work in large metropolitan academic health centres. As a result, the extent to which a practitioner's performance can be reviewed varies. Because Colleges are not health care providers, they are not well placed to detect poor performance in clinical settings and most commonly become aware of performance issues only as a result of regulatory intervention which has resulted in major change to a practitioner's registration status. On the other hand, Colleges hold personal details and training records on Fellows which would technically permit stratification based on the risk factors such as age and gender as outlined in the discussion paper.

The majority of Australian specialists are employed at least part time in the public hospitals system, and are thus covered by a clinical governance system. Similarly, those working in accredited private medical facilities will also be subject to appropriate clinical governance. Proper implementation of performance monitoring programs in these health services would provide an ideal mechanism for the early detection of performance problems as well as a logical pathway for remediation.

From the College perspective, because clinical leaders in health services are almost invariably also senior Fellows of Colleges, it will be important that any confusion between their roles as employers or supervisors and their role as College officers or leaders needs to be minimised or avoided. There is a significant role for Colleges in development and provision of training programs for practitioners who have responsibility for identification of poor performance.

Clinical governance frameworks have also been implemented in many private health services and the RACP considers that these offer similar opportunities for oversight of clinical performance. In settings where no clinical governance arrangements are in place, the avenues for oversight of performance are less obvious. In these situations, the practitioner's CPD returns to the College may well provide the best insight, provided appropriate documentation of actual clinical performance is captured.

A number of specialty groups (usually through their specialty societies) maintain registers of clinical outcomes for specific conditions or for procedures. These could provide an extremely important opportunity for the collection and distribution of comparative outcome data for individual practitioners, thus allowing identification of actual poor performance. If this were to happen, the risk that participation might be inhibited because of perceived risk of criticism or sanction would need to be considered carefully. Effective links between registers and clinical governance processes might well be the avenue by which this risk can be minimised.

The RACP considers that finding a workable and acceptable process for detecting performance problems, real or potential, from reported CPD activities (and then implementing appropriate remediation for these practitioners) is a significant challenge on several levels: especially in terms of the actual authority the College can exert and the resource implications involved.

17. *What do you think about the proposed options for a tiered assessment?*

The RACP is aware of the apparently successful use of the tiered assessment of the risk of poor performance in Canadian provinces such as Quebec, Alberta and Manitoba and believes that a similar approach in Australia would have merit. Given that MSF or similar feedback exercises and practice reviews are being introduced in the NZ recertification framework and are amongst the logical elements by which Fellows could address the performance assessment and outcome measurement requirements of a strengthened CPD model, it will be important to balance any intervention used in a stratified risk assessment process with the integrated approach proposed in Q1. The RACP acknowledges that this could be addressed, in part at least, by steadily increasing the level of scrutiny of documentation of activities rather than by changing the activities themselves.

18. *Can you provide feedback on the proposal that MSF be used as a low cost, effective tool to assess medical practitioners identified as being at risk of poor performance? Are there other cost-effective approaches that could effectively assess medical practitioners?*

The RACP supports further exploration of MSF for this purpose, especially in the further assessment of practitioners already identified as being at risk of poor performance. We noted in our response to Q17 that international experience suggests that MSF is likely to form part of any broad revalidation process, and in many settings, the best indicators of risk are likely to be uncovered by an MSF exercise. The very great advantage of MSF is that it offers an efficient mechanism for gathering focused comments from patients as well as from colleagues and other staff and thus appropriate insight into performance domains such as communication.

We are aware of a range of MSF tools currently used to measure aspects of performance of medical practitioners. These vary considerably in complexity and cost. The two models which appear to offer lowest costs and scalability are the MSF tool offered to UK physicians by the Royal College of Physicians and the MSF tools which form part of the Alberta PAR and the Manitoba MPAR programs in Canada. The RACP does not have access to any formal evaluation data on these programs. It is important to note that the delivery of a full MSF process is not necessarily a trivial cost and requires a significant commitment of time by the candidate and his/her colleagues. In addition to the time and effort of candidate and reviewers, a formal MSF event with aggregation of comments and provision of the

conclusion to the practitioner by an appropriately trained impartial facilitator involves direct costs of around AUD350 per practitioner.

MSF has always been primarily a formative tool in which feedback to participants is the critical final step. A considerable body of formal knowledge and practice exists around the feedback process and in particular, the impartiality of the feedback provider is critical. The RACP expects that any MSF process implemented will preserve this feature and again points to the considerable time and resource commitments involved.

19. *If MSF is to be used, how can Australian benchmarks be developed? What are appropriate sources of comparative data?*

The RACP's current pilot regular practice review program underway in New Zealand has opted to use a commercial provider for the MSF component of the program. This provider controls a very large database of UK experience from comparable discipline and specialty groups which have been used to define initial benchmarks. It is anticipated that Australasian data will be gathered alongside those from the UK and the benchmarks adjusted accordingly over time. Although our experience needs to be seen as preliminary, initial comments suggest that the UK derived benchmarks cannot be transferred directly to the Australasian setting. Similarly, although data collected from the long term use of MSF tools in Canada may well be helpful in providing initial benchmarking data for Australian practitioners, their applicability would need to be assessed before any formal adoption.

The RACP suggests that the issue of MSF benchmarks be approached with considerable caution. Because MSF is largely a formative tool, precise benchmarking parameters are likely to be much less important for the great majority of participants than the qualitative information provided which supports subsequent reflection and quality improvement activity. MSF has only a very limited track record as a summative assessment tool, and in that setting tends to be primarily a hurdle component (i.e. it must be undertaken rather than a specific score achieved). As noted above, the key to effective use of MSF is always the quality of the feedback provided to the practitioner.

20. *Which stakeholders have a role in identifying, assessing and supporting remediation of poorly performing medical practitioners, or those at-risk of poor performance?*

Colleges should remain central to the process of remediation because of the close link to current education and training standards, curricula and supervision pathways. In addition, the Colleges can provide the necessary perspective on practice standards in individual disciplines and specialties. The AMC's accreditation standards for Australasian colleges require that they have processes available for remediation when needed. The RACP's experience since 2011 has been that this is usually for practitioners returning after prolonged absences due to health or family reasons and that the key issue is updating skills and knowledge rather than remediation of performance. Despite this, the model would probably be equally valid for remediation provided the numbers of Fellows involved was small. However these processes are not readily scalable and if the estimate that an appraisal process will identify approx. 5% of doctors performing close to the minimum standard ("at risk of performing badly"), is correct then other processes will be necessary, particularly as these performance issues will have been identified in the context of performance at the work-place.

The RACP supports the proposed view that employers have a role in practice contexts where appropriate governance structures exist. This perspective is strengthened by the fact that impaired performance will usually be evident and acknowledged first in the clinical setting. The concept might even be extended to include doctors in private practice where that practice is carried out in a facility with defined clinical governance arrangements in place (for example, this is the case in most private hospitals). In most settings, a collaborative

approach involving both the College and the employer would offer an ideal way to plan, implement and supervise any remediation.

Assuming that there are effective mechanisms to identify the need for remediation in the first place, Colleges are the logical providers of remediation for any of their Fellows not working under formal clinical governance arrangements, and the AMC accredited mechanisms described above are again applicable, subject to the ability to meet ultimate demand.

Any remediation process implemented needs to ensure that the underlying causes of poor performance have been identified, that the remedial activities are appropriate to address these issues, that the individual is adequately supported and monitored and that a period of "follow-up" is in place. The process needs to ensure that there is appropriate communication between relevant parties (while maintaining a level of confidentiality) and that there is clarity as to where responsibilities lie and who "signs-off" that the remediation process is complete.

21. *What is each stakeholder's responsibility to act on the results of that assessment to address medical practitioners' performance?*

Any stakeholder body assuming responsibility for remedial action will need to have appropriate support structures and processes already in place. The issue of how an individual's reported CPD activity is reviewed and valid assessment decisions made becomes critical if Colleges are to assume this role, and at the same time, the extent to which this is a regulatory role needs to be clarified. We consider that the workplaces will have the first opportunity to observe the impact of remediation, in the same way that they have the first opportunity to detect the poor performance in the first place. A strong collaborative approach to developing programs which meet the professional and educational needs of these practitioners will be essential, particularly when scope and location of practice are taken into account.

22. *What barriers are there for stakeholders to share information about the performance of medical practitioners? How can these barriers be overcome?*

Key barriers here include the current legal context of the relationship between Colleges and the MBA (particularly around the reporting of CPD activity), the extent to which Colleges are willing and able to alter Fellowship status based on current measures of performance and the relationship between specialist registration in Australia and maintenance of Fellowship.

By extrapolating from Canadian experience, the performance of about 5% of practitioners will need to be reviewed formally each year and appropriate learning or remediation plans implemented. The extent to which this is communicated to the MBA and the nature of the documentation involved will need to be determined. The difficulty of sharing information between workplaces, College and the regulator is a very significant potential barrier.

We note also that there is relatively poor understanding of existing mandatory reporting requirements (especially the way these are applied) amongst medical practitioners and suggest that there is very considerable scope for confusion amongst those who might be responsible for any decision regarding risk assessments as well amongst those who might be assessed as being at risk of poor performance.

23. *What are your views about the threshold for reporting poorly performing medical practitioners to the Medical Board?*

The RACP considers that reaching agreement between stakeholders on an agreed reporting threshold will involve considerable further discussion, particularly given the lack of oversight which Colleges have over the actual performance of individual Fellows. The current processes available provide both a mandatory notification pathway and a path for individuals to make notifications to the MBA, but are focused on individual events rather than overall assessment of performance. It would seem reasonable to define a hierarchy for reporting which is based on other models such as the Canadian MEPP program but which sets out as

clearly as possible the transition points between tiers and other key issues (for example, failed remediation at a local level) which would trigger reporting.

24. *Who should be responsible for supporting remediation of identified under-performers who do not meet the threshold for referral to the Medical Board?*

This question is addressed in our response to Q20. For Fellows of the RACP, the College believes that their remediation processes should be supported by the College (especially with regard to planning, supervision and assessment). We suggest that where ever possible, employer or institutional involvement in the delivery and oversight of remediation programs would be a very important step in effecting delivery and ensuring ongoing oversight of clinical activity.

25. *Who should be responsible for identifying, assessing and supporting remediation of poorly performing medical practitioners who are not associated with specialist colleges or organisations with robust clinical governance structures?*

As noted in our response to Q6, the MCNZ offers a formal program for recertification by doctors in non-vocational scopes of practice. This program is provided by an independent contractor and involves strong elements of direct observation, the establishment of a “collegial” relationship with a more senior practitioner in a relevant scope of practice. The RACP is not aware of the extent to which this program includes remediation of poorly performing practitioners but we assume that the model could be explored further without too much difficulty.

The RACP looks forward to further discussion of this important initiative. If you wish to discuss the submission further please contact [REDACTED]
[REDACTED].

Yours sincerely

Catherine Yelland

Dr Catherine Yelland PSM