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MBA proposed approach to Revalidation of Medical Practitioners
Thoughts from the meeting in Darwin 3/11/16

Age triggered review of performance
If the revalidation process is continuous, rather than a "significant event" say every 5 years & punctuating otherwise indolent practice, then age related decline in functioning will become apparent early, triggering closer monitoring and management. Thus there is no need for an age triggered review of performance and it would be a frivolous expenditure of public money to establish yet another bureaucracy with no useful function.

Continuous or intermittent revalidation
If the revalidation process is a regular but infrequent "significant event", conducted every 5 years for example, then it will inevitably fail to ensure medical practitioners maintain currency in their knowledge and skills and will fail to identify doctors whose performance has acutely deteriorated because of, for example, social stress or disease. Like legal practitioners, medical practitioners are skilled at "cramming" and turning in a star performance for the occasion, and there will be those who will do this for intermittent revalidation exercises. "Continuous" however, does not mean constant daily monitoring (although that intrinsically occurs in an environment where there is a whole of organisation culture of understanding of and application of the principles of human error recognition and mitigation – as in the aviation industry). There is some balance point between frequency of monitoring (monthly peer review sessions versus 5 yearly external review for example) and effectiveness of the process: annual monitoring of the nature, extent and timing of educational activities is effectively continuous even though collected annually. Monthly peer review meetings together with an organisational culture and structure of mortality & morbidity reviews and review of error chains leading to "near hits" and Critical Incidents (as in the aviation industry), also are effectively continuous monitoring of performance.

CPD and At Risk & Poorly Performing Doctors
These are two distinct facets of the same issue, but overlap in the sense that effective and maintained CPD is an indicator of lower risk and a safeguard against poor performance. In this sense, it is also an integral part of a remediation process. The reviewing performance and measuring outcomes components of CPD are also obviously key elements in the identification of "at risk" or poor performance, and are likely to be early warning signs if there is change over a period of time. This implies that CPD is quantified in some way.

Quantification of CPD
The education component of CPD is a case of all educational exercises are not created equal and thus some form of quantification will be required. Thus, the background reading and subsequent development of a lecture has a significantly higher value in terms of maintaining currency in knowledge and in internalising that knowledge, than simply attending a lecture (no matter how leading edge it might be).

National Standardisation
The process of Review, whether by regular peer review sessions, external visits, or within a culture of non-judgmental openness (see below), is inherently subjective and therefore subject to the vagaries of interpersonal friction and geography. Thus some form of national standards of, at least, principles of review will be necessary to ensure fairness and inter-jurisdictional equivalence.

Balancing Outcome Measures, Educational Activities and Review Activities
Inevitably, there will be medical practitioners who shine in one or two of the domains of revalidation, but who are judged dismal in the other(s). This then introduces a need for some sort of transparent "weighing in the balance" that arrives at an overall "score" for revalidation that allows for such variation and does not precipitate unfair or unnecessary "significant reviews" of individuals.

Why revalidation doesn't happen anyway & already
The aviation industry went from as unsafe as a war zone to one of safest of all industries (leading the way for the chemical and nuclear energy industries) in about 30 years for the leading airlines, such as Qantas. The Teneriffe Disaster in 1977 marked a turning point in the application of human error theory to change the culture of commercial aviation. Health Services lag far behind aviation in the cultural change that embeds understanding of human error in the moment to moment operation of medicine. With the exception of anaesthetics, medical disciplines pay lip service to error management, with morbidity and mortality meetings and clinical governance committees more attuned to explaining away problems, than sustaining a culture of non-judgmental openness. What has this to do with revalidation? Maintaining a culture of "error awareness" leads to self reflection, and an ongoing drive to minimise errors, human and organisational, that inevitably spills over into self-reflection about medical performance, making normal the continuous questioning of oneself.

The relentless bureaucratisation of health, and the insidious rise of managerialism, acts directly to exacerbate the risks of error since, by and large, bureaucrats and managers are not clinicians, and have even less idea about human error in the domain of health. Thus they have a propensity to act to oppose development of a "human error aware" culture, and the development of the self-reflective clinician which lies at the heart of revalidation.

The most effective stimulus for the "self-reflective professional" then, is to mandate and fund human error and patient safety training for ALL members of health services, from patient care assistant to chief executive. The same training can be mandated as part of general registration of medical practitioners, with 5 yearly refresher courses. This training is reflected in the Reviewing Performance "peer discussions of cases, critical incidents etc" together with the Measuring Outcomes "Mortality and morbidity reviews".

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