The Cardiac Society of Australia and New Zealand

Response to Medical Board of Australia Discussion Paper

Options for Revalidation in Australia

INTRODUCTION

The Cardiac Society of Australia and New Zealand thanks the Medical Board of Australia for the opportunity to provide feedback on the Discussion Paper – "Options for Revalidation in Australia".

The Cardiac Society of Australia and New Zealand (CSANZ) is the principal professional society supporting cardiologists and those working in the area of cardiology including researchers, scientists, cardiovascular nurses, allied health professionals and other healthcare workers. With over 2000 members, the CSANZ is one of the largest medical professional organisations in Australia, responsible for postgraduate education, professional development and practice standards. The CSANZ aims to facilitate training of health professionals, promote continuing professional development and to improve the quality of care for patients with cardiovascular disease in Australia and New Zealand.

The CSANZ supports the general principles underpinning the approach to revalidation and agrees with the concepts of an integrated approach to revalidation and the inclusion of a "strengthened CPD". The CSANZ recognises both challenges and opportunities for the profession in the development and implementation of a robust, effective, valued and sustainable program of revalidation. The following document provides a brief background about the CSANZ and detailed responses to the questions raised in the Discussion Paper.

The CSANZ has already been working towards a program of "Strengthened CPD", including provision of content and self-assessment tools for practitioners, as well as registries of clinical outcomes and safety and quality audit. **In furtherance of the aligned objectives of the two organizations, the CSANZ wishes to express interest in working with the Medical Board of Australia on pilot implementation of the revalidation program.**

Richmond Jeremy

Chair, CPD Committee CSANZ

Past President CSANZ

RESPONSES TO QUESTIONS FOR DISCUSSION

PART ONE: A STRENGTHENED CPD PROGRAM

Proposed Approach

The fundamental purpose of revalidation is to ensure public safety in healthcare. The EAG is proposing two distinct components that will help achieve this in the Australian healthcare setting:
1. maintaining and enhancing the performance of all doctors practising in Australia through efficient, effective, contemporary, evidence-based continuing professional development (CPD) relevant to their scope of practice ('strengthened CPD'), and

2. proactively identifying doctors at-risk of poor performance and those who are already performing poorly, assessing their performance and when appropriate supporting the remediation of their practice.

The EAG advocates an integrated approach that involves developing these two components at the same time.

Question 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 CSANZ considers that an integrated approach is essential to effective realisation of the two components of revalidation. The strengthened CPD program should deliver content, audit and assessment tools which are relevant to the practitioner and which are valued by the practitioner. At the same time, the facility for early identification of underperforming or at-risk doctors should be built into the CPD program, so that review and assessment of knowledge, skills, performance and attitudes is a continuous part of professional development and workplace review.

The program seeks to improve performance of all practitioners and should therefore include provision of content that is both generic as well as that which is practitioner-specific. The CSANZ has been developing a CPD program specifically oriented to such content provision. An essential feature is facility for practitioners

to identify their own learning needs and to select from a variety or educational opportunities. Each practitioner will require both core or essential material as well as more elective material. Achieving appropriate content balance and workload will require informed planning based upon knowledge and insight into practice environments and professional needs and aligned with the principle of "Smarter not Harder" as identified in the EAG document.

The pro-active identification of underperforming or at-risk practitioners should not be a separate entity, but rather should be a key element of strengthened CPD, using a variety of instruments. Thus, all practitioners should be engaged in self-assessment, audit and peer review, which is an ongoing and seamless component of the strengthened CPD program. The nature of the assessment and review tasks should address both generic and practice-specific knowledge and attributes. To date, CPD programs have not well addressed this challenge. The CSANZ has therefore developed new facilities for cardiology, including on-line content learning and assessment, new registries in cardiac procedures and patient outcomes and is now developing new tools for clinical practice audit.

The CSANZ is strongly placed in the Australian environment to develop and provide tools for identification of struggling practitioners thought the registry program. Our registries are well established with proven track records. They receive international recognition for their role in service development/provision/planning. The CSANZ proposes developing a pilot model for the identification of underperforming practitioners during 2017. The registries would be integrated into a strengthened CPD program.

Question 2:

Are there other approaches that could feasibly achieve these aims?

Whilst other approaches can be envisaged, which may range from formal education courses to re-licensing examinations, these are likely to be impractical and potentially unreliable. The wide range of practice environments and different areas of knowledge and skills weighs heavily against a centralised approach.

As the majority of issues associated with at-risk or underperforming practitioners are related to workplace interactions, formal examinations are unlikely to detect such practitioners. A robust program of self-reflection, assessment and ongoing review in the real practice environment is required to identify these practitioners. The validity of such identification by examination is low whereas validity of workplace and practice identification is high.

The CSANZ also considers that the feasibility of the program will be heavily dependent upon engagement of practitioners and specialty groups to contribute to the development of the program and therefore a sense of "ownership", which is unlikely to develop if a program is administered as a formal education or examination process by a third party.

Question 3:

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

The experience of the CSANZ in promoting enhanced CPD allows identification of a number of potential barriers to implementation, and prospective planning of strategies to overcome them.

Firstly, whilst the majority of practitioners recognise the value of CPD in promoting better patient outcomes, their perspective is largely one of benefit to themselves through improved knowledge and skills, with the patient benefits as a secondary or flow-on effect. Whilst this perception is to some extent correct, it misses the key element of audit and self-assessment against standards. This focus also largely ignores issues of appropriateness of practice. In order to address this perception gap, an information and education program is an early requisite. At the same time, CPD programs should begin providing opportunity for practitioners to self-challenge their perception and use of CPD.

Any program requiring additional task performance is likely to meet initial negative reaction from practitioners. As well as building CPD tasks and performance assessments into the daily work-flow as much as possible, it will be important to demonstrate value to participants, through provision of relevant content and feedback about performance.

There is a risk of poor 'buy-in" by practitioners, which is more likely when the program is developed externally or regulated by third parties. If practitioners and the craft groups with which they identify are closely involved in development and delivery of the program, then willing and enthusiastic participation is more likely.

As noted above, the program should be well articulated to the practitioner's work environment and demands and whilst it must be efficient and effective, it should not be overly burdensome. The risk of a program which is complex or very demanding is that compliance will be fragmentary and in all likelihood superficial and meaningless.

Another risk is that practitioners may perceive the program to be of little practical relevance and simply a device to satisfy regulatory authorities. The program will necessarily include material and assessments of

generic nature, however the real value will also lie in inclusion of material, which is well aligned to the practitioners' fields of work. This will require close involvement of relevant craft groups in the development and delivery of the program. There should be flexibility in engagement of these craft groups, as "one size does not fit all". Delivery of pilot programs through craft groups with current experience, such as CSANZ, can accelerate program modelling and implementation.

Participants should be assured of the transparency and accountability of the program. The CSANZ has a longstanding and strong reputation as a trusted professional organisation by its members. The delivery of the program in concert with organisations, with which practitioners already have a supportive and positive relationship, will enhance the quality of participation.

A current deficiency of many CPD programs is the lack of availability of tools for key elements such as clinical audit and peer review. The CSANZ and other groups have been working to redress this deficit and the provision of relevant tools and assessment instruments should be an early feature of the new program.

Guiding Principles

The EAG has proposed that the following guiding principles apply to all recommended approaches for revalidation:

*· _**smarter not harder**: strengthened CPD should increase effectiveness but not require more time and resources for participants*

*· _**integration**: all recommended approaches should be integrated with – and draw on – existing systems where possible and avoid duplication of effort, and*

*· _**relevant, practical and proportionate**: all recommended changes should be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.*

Question 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 CSANZ strongly supports these Guiding Principles as key foundations of the proposed program. As is noted above, these principles can support approaches, which can obviate or overcome many of the identified barriers to implementation.

It can be argued however, that the three Principles, as listed, are predominantly from the perspective of the regulatory authorities or the administering bodies, but not necessarily from the perspective of

participants. The CSANZ would therefore propose an additional Guiding Principle, as follows:

engagement – the strengthened CPD should be identified by practitioners as an important practice resource and a key tool in supporting their safety of practice

The importance of this principle should not be underestimated as its successful application will underpin the effectiveness of the program, facilitate program uptake and increase the reliability of program assessments and feedback to both practitioners and relevant statutory authorities. This principle can change the perception of the program from "something they make us all do so we can practice" to "something we all do so we practice better".

Strengthened CPD

The EAG recommends that strengthened CPD, developed in consultation with the profession and the community, be a central focus of revalidation in Australia.

The EAG reports that CPD is continuing to evolve and we now have the opportunity to strengthen Australia's CPD system for medical practitioners so it is more effective, flexible and dynamic. Evidence-based and principles-based approaches will best drive practice improvement and better patient healthcare outcomes, and meet future needs. Given the distribution of registered medical practitioners within and outside specialist medical college structures, the EAG believes that all proposed changes to strengthen CPD must apply and be accessible to all registered medical practitioners. The EAG also believes collaboration where possible with existing clinical governance processes, including credentialing, practice accreditation and safety and quality audits, is important rather than duplicating processes.

Question 5:

How can evidence-based strengthened CPD be achieved?

The CSANZ considers that the terminology of the EAG recommendation above should be amended to read as follows:

The EAG recommends that strengthened CPD, ***developed by the profession, in consultation with the regulatory authorities and the community****, be a central focus of revalidation in Australia.*

As noted above, objectives of practitioner engagement and meaningful participation are of critical importance to the real success of the program. An externally developed program is much less likely to be successful in meeting these objectives than is a program developed within the profession and this is particularly important when key matters of practitioner relevance are considered. The strengthened CPD program should not, however, be developed in isolation by the profession. The CSANZ considers it a fair criticism of existing CPD programs that the involvement of other stakeholders, including statutory authorities, health service providers, safety and quality agencies and the community has been insufficient. The CSANZ believes that a strengthened CPD program, developed by the profession in consultation with such stakeholders and also adhering to the principles and framework established by the regulatory authority has the greatest likelihood of successful implementation in the shortest reasonable time frame.

The CSANZ can identify several key strategies, which can support implementation of evidence-based and strengthened CPD.

Information Sharing: **"we need to talk about this"**

At this time, understanding of the challenges facing revalidation and strengthened CPD is fairly limited within the Australian medical community. There is pressing need to raise awareness and discussion of these matters and thereby begin the process of professional engagement. Whilst timing of information flow is a matter of balance, an early program of graded increase in information and communication through multiple forums is likely to be beneficial.

Frameworking: **"we need to know how to build this"**

Given the wide variety of professionals and disparate practice environments in the medical community, it will be necessary to tailor the program to fit multiple different situations and needs. There must however be an underlying framework, aligned to the program objectives, which can provide necessary common functions, evaluations and assessments and also commonality of systems for identification and assistance of practitioners at-risk or in difficulty. This framework should be developed as a first step, in consultation with stakeholders, so that subsequent devolution to CPD providers can be undertaken in a coherent manner.

Consultation: **"we need to learn from others"**

There are multiple stages of consultation required. The first is already underway through the present Discussion Paper. Development of the program framework will require consultation with stakeholders, as identified above, regarding key elements, procedures and outcomes to be measured. Further consultation

with peer organisations with relevant experience can further inform framework development. Subsequent development of the program details, content and tools will require consultation with craft groups and practitioners. Pilot program evaluation will require review and consultation with all stakeholders and with program participants.

Devolution: "we can't do this alone"

Current experience has shown that centralisation of CPD programs can result in disengagement of participants and fail to foster development of the necessary content and assessment tools relevant to participant groups. Within the defined program framework, devolution of CPD development and implementation to professional groups with appropriate experience will allow for faster implementation of the program, better alignment to practitioner needs and more efficient delivery. As unwarranted duplication of activities is to be avoided, the use of a "hub and spoke" approach may be useful, whereby certain administrative functions may be centralised, whilst educational, assessment and audit functions are devolved. In general, devolution to relevant entities can better support remediation and assistance to practitioners in difficulty than can a more centralised, "authoritarian" approach.

Pilot: "we need to walk before we run"

The introduction of the new program will be a major undertaking and faces a variety of obstacles as described above. The use of a pilot program, through a few professional entities with demonstrated interest in CPD, can allow early identification and rectification of matters of concern, as well as providing early data on utility and benefits of the program.

Evaluation: "are we doing the right thing"

The new program will be vulnerable to criticism of being self-serving or a "closed-shop" unless it explicitly demonstrates that it will be subject to critical review and evaluation. This evaluation should be undertaken by an independent body, such as a University or Health Research Institute, with relevant expertise. The results of evaluation should guide program evolution and improvement and should also be available to stakeholders to demonstrate how well, or otherwise, the program is meeting objectives.

Review and Continuous Improvement: "how can we do better"

The results of both internal and external evaluation studies should guide progressive improvement of the program. In the early years, when a staged introduction may be desirable, evaluation results can inform subsequent stages of program delivery. Participants will expect that the program is accountable, reviewed and responsive to feedback and stakeholder concerns.

Question 6:

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

The CSANZ recognises that existing CPD programs are inadequate to meet the challenge of timely introduction of effective and meaningful "strengthened CPD". The new program will require instruments and capabilities, which are not available in existing programs. A more complex matter is the perception that existing CPD programs are simply point-scoring exercises for many practitioners and "participation" lacks validity in many cases. A new approach is required if the present deficiencies are to be overcome in a timely and effective manner. Incremental change of existing programs carries the real risk of prolonged delivery time-lines and shortfall in program deliverables.

A number of key roles can be identified for the strengthened CPD program, including:

Consultation:

As noted above, there are multiple stakeholders who should be consulted at different stages of program development and delivery. Responsibility for ensuring this consultation occurs and is acted upon rests with the party responsible for each stage of program implementation. Thus, the present strategic development and associated consultation is overseen by the Medical Board of Australia.

Framework Development:

The CPD framework will need to provide a unified platform for the program and therefore should be developed "centrally, in consultation with stakeholders". This framework development should be overseen a core group including representatives of the Medical Board of Australia, Australian Medical Council and the medical profession.

Program Development and Delivery:

As noted above, the CSANZ considers that targeted program development and delivery should be devolved to professional organisations with relevant interest and expertise, which should include specialist medical societies as well as current Colleges. There may also be a role for inclusion of specific educational bodies, such as Universities, in this process. The CSANZ believes that a broader involvement of professional bodies, beyond the current College CPD approach, will result in faster development of the program, better articulation to practitioner needs and better engagement by practitioners with the program.

Reporting:

The reporting and collation of practitioner assessments should in the first instance be the responsibility of the organisation overseeing program development and delivery. Subsequently this data needs to be reported to the more central organisation, such as the Medical Board or its designated agent.

Remediation and Practitioner Assistance:

The process of assistance and remediation for at-risk or underperforming practitioners should be the responsibility of the professional group most closely aligned with the area of practice of the individual concerned. Referral to "organisations at a distance" should be avoided. The approach to assistance and remediation should be tailored to individual needs, yet firmly based upon agreed principles and outcomes according to the program framework.

Program Evaluation:

The evaluation of the program should be responsibility of both the body responsible for program development and delivery (self-evaluation) AND an external agency (independent evaluation) as described above. The evaluation findings should be communicated to the governing body (eg Medical Board) as well as the program provider.

Governance:

Careful consideration of program governance is required, as both a central "oversight and strategic" governance of the entire program will be required as well as reportable, operational governance by the bodies responsible for program development and delivery.

Question 7:

Are there any unintended consequences of this approach?

The CSANZ supports the EAG recommendation that "*collaboration where possible with existing clinical governance processes, including credentialing, practice accreditation and safety and quality audits, is important rather than duplicating processes."*

The greatest potential unintended consequence is that the revalidation program leads to distortion of medical practice – eg "I wont take this patient management risk because I might be audited by them…". It will be vital that this risk is managed through information, education, transparency of process and

engagement of practitioners in a process they see as supportive rather than punitive or regulatory. A corollary consequence can be resentment of a program seem as overly intrusive.

In the long term we must avoid creating a professional environment which is seen as a straight-jacket or so burdensome that career choices of potential future medical practitioners are adversely influenced –"I wont do medicine – the paperwork and admin is too much of a nuisance".

Another unintended consequence may be reduction of the program "to the lowest common denominator". This is a difficult balance. It is necessary to have fundamental criteria and mechanisms, which effectively identify the small proportion of practitioners at-risk or underperforming. On the other hand, this risks the vast majority of practitioners feeling that the program is not applicable to them or of no personal use – "It is only to weed out the bad eggs…". Resolution of this issue will require a careful and graded series of performance standards such that all practitioners can find something of challenge, which can foster further development. The aim is to support continued improvement of all practitioners.

There may be adverse consequences upon medical workforce levels. Thus, undue focus on certain groups (eg practitioners over age 50) as an early initiative may have the unintended consequence of stimulating an early departure from the workforce of these practitioners.

Question 8:

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

Currently, health services and hospitals in many regions within Australia provide courses aimed at fostering patient safety in the hospital environment. The formal training and medical education provided is directed principally towards junior medical staff, whilst more generic matters, such as infection control and communication, are directed towards all staff. The process of communication, described above, should involve definition of both the needs and offerings of the hospital and health service education programs. Development of the CPD program should specifically address these matters. The health services and hospitals should have opportunity to provide feedback about the program.

The health service and hospital environment is a key source of practice and performance review for many practitioners and the program should involve relevant members of the health service in practitioner review and audit. This can include other members of medical staff, nursing and allied health staff and potentially

patient feedback. The groups responsible for development and delivery of the program should seek early involvement of the health services and hospitals in these processes.

Equally, we must address the needs of individuals is private practice, who may not be linked to a hospital service. Professional groups such as the CSANZ have a key role in the engagement and support of these practitioners through strengthened CPD and provision of audit and review tools and opportunities. Other key groups include practitioners in rural and remote locations, for whom on-line material, such as the CSANZ HeartOne program are a vital resource. Similarly, peer-oriented meetings and exchange can be facilitated by professional groups such as CSANZ.

Guiding Principles

The EAG has proposed a set of guiding principles for all CPD in Australia. These guiding principles are designed to make sure that the CPD that medical practitioners routinely undertake as a requirement to renew their registration each year is effective.

Question 9:

Is each of these principles relevant and appropriate?

The CSANZ considers that the listed principles are relevant and appropriate, although not completely comprehensive (see response to Question 10). The principles of focus on the role of self-reflection and focus on outcomes that individual doctors wish to attain could be combined. Individual doctors handle self-reflection poorly in many cases and this element will need working through with comparisons to practice benchmarks, adverse event reporting and appropriateness of practice criteria.

Similarly, the principles of “are led by the profession” and “encourage collaboration within the profession” could usefully be combined.

Question 10:

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

The focus upon outcomes that individual doctors wish to attain is commendable and an important principle. The three core types of CPD proposed by the EAG are an advance on those currently administered and are well aligned with the approach of the CSANZ. Our current program with the addition

of the registry measures that we propose developing next year would be an excellent fit. In addition to the focus upon matters identified by the individual doctor, there needs to be a focus upon matters identified by others (eg Medical Board, legislation), which ALL doctors must address. The CSANZ would suggest that consideration be given to inclusion of a principle that

High Quality CPD Programs – provide key material required of all medical practitioners

A limitation of many CPD programs is the absence of an appropriate suite of tools for clinical audit and assessment of practitioners (including self assessment and peer review). As these are important elements of a CPD program and revalidation program seeking to improve patient safety and outcomes, the CSANZ suggests that consideration be given to inclusion of a principle that:

High Quality CPD Programs – provide a comprehensive set of tools to support practitioner assessment and clinical practice audit

Three core types of CPD

The EAG proposes that medical practitioners in Australia should participate in three core types of CPD, with activities prioritised to strengthen individual performance.
All recognised CPD activities would be evidence based and involve:
1. performance review

2. outcome measurement, and

3. validated educational activities.

Question 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 proposed triad model for strengthened CPD represents a significant advance over current CPD offerings and is fundamental to any program, which really seeks to improve patient safety and outcomes. Current programs do not well address Reviewing Performance and Measuring Outcomes. Many practitioners may initially find these elements threatening, hence the need for dialogue and information as

noted above. There is a need for development of relevant audit and assessment tools, again as noted above.

The CSANZ would also recommend that issues of appropriateness of practice criteria be addressed through this triad, particularly as these criteria are developed and refined in coming years.

Question 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?

The CSANZ recognizes three principal implications.

The first is the need for development of appropriate valid, reliable and practical tools for performance review and outcome measurement. These tools should include both generic sets and more practice specific sets.

The second is the need for effective mechanisms for involving hospitals and health services in the review and assessment process. It will be necessary to develop processes, which support easy contribution by hospitals and similar workplace environments. This will involve a level of communication between parties, which has not existed to date.

The third is the need for a system validation and recognition of educational activities. Unlike Europe and the USA, there is not a well-defined system for review, accreditation and credit point allocation of most CME activities in Australia. This lack can result in very disparate educational activities receiving similar weighting in current CPD points scores. Careful discrimination of activities which merely apply current knowledge (eg teaching and writing), versus those which truly advance a practitioner's knowledge and skills is required. Many practitioners attend lectures and conferences, which are passive and associated with lower levels of information retention and lesser influence upon practice. The program developers must foster active learning, early self-assessment, feedback and refreshment. The role of development of skills and personal attributes (including communication and peer interactions) are poorly addressed by current CPD programs.

Question 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?

Within Australian society, freedom of choice and marketplace competition are two key public principles. At first glance, the proposed triad of performance review, outcome measurement and validated educational activities, may pose a considerable challenge to some medical practitioners undertaking self-directed programs. These practitioners may have particular difficulty in meeting requirements of peer review and clinical audit. Several solutions are, however, possible.

One solution would be to mandate that all practitioners must do their CPD and revalidation through one of a limited number of College CPD programs. Such a solution may not be well aligned with or appropriate for an individual's practice profile and needs. Furthermore, such an approach violates the principles of freedom of choice and marketplace competition. Provision must therefore be made for individual practitioners to choose their revalidation program components and to do so with reasonable equity of access.

Organisations which are approved for development and implementation of CPD and revalidation should be prepared to make available relevant toolsets and assessment instruments to all practitioners who request them for purpose of their personal CPD and revalidation, whether or not they are a member of the organisation. For those individuals, who are not members of the organisation, an appropriate fee may be payable for access to and use of these instruments.

Individuals undertaking self-directed programs will be required to lodge their CPD and revalidation materials for collation and registration each year. Again, any organisation involved in CPD and revalidation should have capability to receive such submissions and forward the relevant information to the registration authority. Although a fee may be payable for such lodgement, such fees should not be unduly onerous and should not be much greater than simple cost recovery.

Finally, the Medical Board may wish to consider a system in which an individual practitioner can lodge her/his CPD and revalidation material directly with the Board at time of application for registration renewal. On one hand this carries resource implications, however such an approach would improve equity of access for all practitioners and would facilitate audit and identification of at-risk practitioners through data-matching and profiling algorithms. In the longer term, this approach may well be the preferred choice.

PART TWO: AT RISK AND POORLY PERFORMING MEDICAL PRACTITIONERS

The EAG reports on international evidence that a small proportion of medical practitioners are not practising to expected standards at any one time, or over time. Another group of medical practitioners is 'at-risk' of performing poorly.

The view of the EAG is that developing accurate and reliable indicators to identify 'at risk' medical practitioners and intervening early has the potential to improve patient safety, improve medical practitioner performance and reduce the adverse impacts of patient complaints on complainants and medical practitioners. For this a better safety net is needed to identify and assist doctors at risk of or demonstrating performance that does not meet accepted standards. Improved remediation processes with clear accountabilities are also needed.

Question 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?

This is a key requirement of a revalidation program, which seeks to identify such practitioners in a cost-effective manner. This data can also inform the development and targeting of CPD and review and assessment in delivery of the program to the community of medical practitioners.

The CSANZ suggests that further research, with specific reference to Australian workforce and workplace are required and advises that some caution may be required in extrapolating findings from other countries. With it's well established governance structures and organisation the CSANZ is well placed to undertake such research.

The detection of underperforming colleagues can be a difficult process and there are many causes of underperformance. Simple risk profiling may not detect those at greatest risk. Organisations such as CSANZ can contribute to both identification and support and remediation of such practitioners.

Question 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?

Some caution may well be warranted in the promulgation or application of specific approaches to these groups, particularly as many practitioners are already over 30 years of age when they finish their training and half of medical graduates are now female.

Further research and careful prospective data collection will be required within the Australian context and should be facilitated by a coherent revalidation framework (see above).

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

The answer to this question is similar to that for Question 20 below. All members of the health care team, including peers, co-workers in nursing and allied health staff and also on occasion health service administrative staff, can play a part in the identification of at-risk and poorly performing doctors. The strengthened CPD program can also provide a mechanism through clinical audit and outcomes reporting.

The essential question is how to establish mechanisms, which facilitate early identification, whilst preserving principles of privacy and confidentiality and natural justice. Several key elements can be identified.

Firstly, the revalidation program should be well publicized to all stakeholders, not just medical practitioners. This should include informed definition of the issues, which would raise concerns about a medical practitioner's performance. At the same time, all stakeholders should be aware of their individual and group responsibility to the community about raising concerns about a practitioner.

Secondly, there should be a clear and independent pathway for communication of concerns. This could be through a hospital clinical governance and oversight process or, alternately, there should be provision for communication direct to the Medical Board (particularly for non-hospital situations). Upon notification of concerns about practitioner performance, the body administering the revalidation program relevant to the individual practitioner should be notified and the process of tiered assessment commenced.

Clearly there is considerable detail to be worked through in the implementation of this approach, however at this early stage the key principles can be identified as:

1) Education, information and transparency of purpose so all stakeholders understand the process
2) Clear and established channels of communication
3) Independent review and assessment of the issues by a group with relevant expertise

Assessment: scaling the assessment to the level of risk

Most of the practitioners in the at-risk groups will be able to demonstrate that they are performing satisfactorily, just as most people who are screened in a public health intervention do not have the disease for which the screening program is testing.

The EAG has identified that some medical practitioners who are under-performing, will return to safe practice simply through the process of being assessed.
The EAG also points out that there are medical practitioners who are not in a high-risk category who are not performing satisfactorily.
The EAG recommends a tiered series of assessments, starting with cost-effective, early interventions as screening tests and then further assessment if needed.

Question 17:

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

The proposal for a tiered assessment depends heavily upon identification of at-risk practitioners, who would initially undergo a multi-source feedback (MSF) review. The identification of such at-risk practitioners is imperfect, as the EAG acknowledges. Care should be taken with such risk-profiling, as there are a large number of male practitioners aged over 35 years and it is not likely to be practicable to do MSF on all of these individuals. Indeed, unless the predictive accuracy of the profiling is high, such profiling may perform little better than random sampling. As noted above, more research is needed to improve risk-profiling in the Australian context.

Furthermore, the whole matter of risk-profiling raises issues of civil liberties, discrimination and potential harassment.

Unless and until risk-profiling can be demonstrated to have a high predictive value, the use of MSF and tiered assessment may be better applied as a random audit and/or after trigger events. There is otherwise the risk of significant overuse of resources and also risk of civil complaint.

Important matters for consideration will be how often such assessment should be undertaken, who should actually perform the assessment, what appeal avenues the assessed practitioner might have and what training the MSF assessors should have to complete.

There is presently not sufficient information provided about proposed Tier 2 and Tier 3 assessments for response in detail. The CSANZ suggests that only two Tiers of assessment may be required, provided the process is robust. The proposed Tier 3 may be better merged with a program of supervised remediation and on-going re-assessment and support.

Question 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?

It is not certain that the MSF will be a low cost assessment tool, given the time required for its administration, the number of participants giving feedback, the need for development of specialty-specific instruments and the need to train assessors. As noted above, the application of current risk-profiling may well be an imperfect selector of at-risk practitioners.

There are a number of potential approaches, which may help resolve these issues.

Firstly, a simplified MSF proforma may be required for all medical practitioners and should be submitted within each 3 years of a revalidation cycle. This simplified MSF could be a standard format for all practitioners, employing standard rating scales and addressing fundamental issues relevant to patient safety. Those practitioners, whose simplified MSF raised concerns, would then be referred for the proposed Tier 1 specialty-specific MSF.

Additional risk-stratification information can be obtained from analysis of each practitioner's annual CPD returns, including content, pattern and time of return completion, responses to assessments and clinical audit outcomes. The initial MSF should NOT be seen as the first step in a punitive or remediation process, but simply as an information-gathering exercise and an opportunity to explore any challenges or issues the practitioner may have and to discover what additional support the practitioner may seek.

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

There are two approaches to evaluating the outcomes of the MSF process. As the discussion paper notes, benchmarking is one approach, however there is little Australian data available at present and therefore the program may well initially rely on data from comparator health services, such as those in the United Kingdom, provided the limitations of such data in the Australian context are recognised. As the revalidation program progresses, prospective collection of Australian data can inform better benchmarking for the local environment.

Benchmarking may well be regarded, however, as a form of normative scoring, as distinct from actual criterion referencing. It can be argued, however, that the latter is the more important measure for performance assessment, particularly for key matters related to patient safety.

Therefore, a potential practical approach to the introduction of MSF would be to establish initial clear criteria for satisfactory or unsatisfactory performance, which can be applied in both an advisory (formative) or a barrier (summative) assessment. These initial criteria should be relatively straightforward and easily understood. If the initial MSF program is too complex it may well be unsustainable. As the program progresses, the MSF criteria can be reviewed and adjusted according to accumulated performance data (benchmarking) and also in response to the evolving medical practice environment. An advantage of the criterion-referenced approach is that multiple stakeholders (eg hospitals and peers) can have constructive input into the criteria development and review.

Poorly performing medical practitioners

The EAG believes it is important to define accountabilities and responsibilities for identifying and assessing under- or poorly performing medical practitioners and supporting their remediation. The EAG also raises the following as issues:

· _the thresholds for reporting medical practitioners to regulators in the context of poor performance

· _who is responsible for supporting and assisting the remediation of identified underperformers who are not referred to the regulator because they do not meet the threshold for regulatory referral, and

· _how under- or poor performance among medical practitioners who are outside colleges and practise outside organisations with robust clinical governance structures are best identified and managed.

Question 20:

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

The principal stakeholders who have a role in identifying at-risk or poorly performing medical practitioners include all those members of the health care team interacting with the practitioner (medical peers, junior medical staff, nursing and allied health staff). The communication of concerns will usually be through clinical governance pathways at a hospital or clinic. In other settings, concerns may be communicated by peers or patients through established health care complaints systems. There may also be concerns raised as a result of the practitioner's CPD or clinical audit annual returns. Once such concerns have been raised, then the tiered process of assessment should be initiated.

The principal stakeholders with a role in assessing at-risk or poorly performing medical practitioners include the organization responsible for delivery of the CPD and revalidation program and independent medical referees with relevant expertise. The peers and hospital staff may provide input to the assessment itself, however should not be responsible for the assessment.

The principal stakeholders with a role in supporting remediation of at-risk or poorly performing medical practitioners include the organization responsible for delivery of the CPD and revalidation program and independent medical practitioners with relevant expertise. The peers and hospital staff may provide input to the remediation process, however should not be responsible for the structure and review of the remediation program.

Question 21:

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

Once an assessment of an at-risk or poorly performing practitioner is completed, the assessment should be reviewed and recommendations made by an appropriately constituted Professional and Ethical Standards Committee, within the organization delivering the CPD and revalidation program. The organization then has

responsibility to notify stakeholders, including the Medical Board, health service and hospitals, and relevant peers of the outcome of the assessment, the recommendations arising and the planned program of remediation and re-assessment.

The subsequent delivery of the remediation program is the responsibility of the organization delivering the CPD and revalidation program, including reporting to the Medical Board on progress and outcomes.

Question 22:

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

The barriers are related to the key issues identified in Question 16.

Lack of understanding of the purpose, process and opportunities afforded by the CPD and revalidation program will hinder use of the program. All stakeholders should be well informed and familiar with the program and its provisions.

Absence of clear paths of communication and also of appropriate safeguards regarding privacy and natural justice will inhibit reporting and information sharing. There may need to be more than one path of reporting.

Independence of the assessors and confidentiality of reporting and assessment are key requirements.

The new program will require considerable resource support and this burden should be reasonably distributed between stakeholders. The failure to adequately resource the program may well lead to delays in action on concerns, incomplete assessment and rectification. This would in turn lead to cynicism and disengagement by stakeholders.

The program should not be overloaded by an excessive case load and this is therefore a key consideration for risk-profiling (see above).

Question 23:

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

This matter will require careful dialogue between the Board and the stakeholders described above. It is likely that a tiered threshold approach will be required.

A clear fundamental threshold would be if concerns were raised that a practitioner's performance was directly placing patient lives at risk or a potential cause of major morbidity. Such concerns should be reported immediately to the Board and the Board may wish to issue a direction regarding interruption of practice for a period of time.

A second threshold may reflect concerns about practitioner approach, appropriateness of practice or current knowledge and skills. Such cases may not require immediate notification to the Board, however they should be notified through the established processes described above. In the event that tiered assessment uncovered major concerns about practitioner performance and/or the practitioner did not demonstrate appropriate and successful remediation, then the Board should be notified.

The Board may wish to define specific issues which would require mandatory and immediate reporting to the Board.

Question 24:

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

The principal stakeholders with a role in supporting remediation of at-risk or poorly performing medical practitioners include the organization responsible for delivery of the CPD and revalidation program and independent medical practitioners with relevant expertise. The peers and hospital staff may provide input to the remediation process, however should not be responsible for the structure and review of the remediation program.

Question 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?

These practitioners require assistance in the same manner as those described above in Question 24 and they should be referred to the clinical practice group most relevant to their individual practice. Attempted remediation outside a program associated with established governance and educational and assessment support is unlikely to be successful. The Medical Board would not be in a position to undertake the remediation, nor would it be appropriate for it to do so.

The CSANZ and Current Continuing Professional Development

The Cardiac Society of Australia and New Zealand (CSANZ) is the principal professional society supporting cardiologists and those working in the area of cardiology including researchers, scientists, cardiovascular nurses, allied health professionals and other healthcare workers. The CSANZ is the chief advocacy group for the profession and aims to facilitate training of health professionals, promote continuing professional development and to improve the quality of care for patients with cardiovascular disease in Australia and New Zealand.

The CSANZ in Australia and New Zealand currently includes over 2000 members, whose professional practices include clinical cardiology, cardiothoracic surgery, cardiovascular nursing, echocardiography and cardiovascular research.

The CSANZ has been involved in professional education for cardiologists and associated professional groups for over 50 years. The key activities of the CSANZ include:

Scientific Meetings and Workshops

A major activity is the organisation of an annual scientific meeting (ASM) focused upon research and clinical practice developments in cardiology and related fields. The ASMs are multidisciplinary and include basic science and clinical practice educational activities. The meetings are designed to provide information and peer interaction for cardiologists, cardiothoracic surgeons, research scientists, cardiovascular nurses, cardiac technicians and trainees in each of these fields. In addition, the State branches of the CSANZ organize local cardiology meetings and workshops throughout the year.

Clinical Practice Guidelines and Position Papers

The preparation and publication of clincial practice quidelines and position papers by expert writing groups has been a major educational activity for over 20 years. The CSANZ has also collaborated closely with the National Heart Foundations of Australia and New Zealand in the preparation of important guidelines in cardiovascular disease prevention and management. These guidelines are widely used by cardiologists, physicians and general practitioners in Australia and New Zealand and are a fundamental contribution to defining standards of care. Guidelines are regularly reviewed and updated in order to present the latest evidence and recommendations.

Postgraduate Training and Standards

The CSANZ has been responsible for making recommendations on postgraduate subspecialty training in cardiology and for describing the standards of training and practitioner experience required in specific fields of cardiology practice. Importantly, many of these standards also include recommendations regarding continuing practitioner experience and professional development

Heart Lung and Circulation Journal

In 2004, the CSANZ entered into a collaborative agreement with Australasian Society of Cardiothoracic Surgeons, with the purpose of supporting an integrated journal of cardiology and cardiothoracic surgery. In the decade since, the journal, Heart Lung and Circulation has grown to monthly publication with an international profile and authorship. The journal publishes original articles, expert reviews and clinical practice guidelines and is an important contributor to the CSANZ effort in professional education.

HeartOne

The CSANZ has further expanded its educational activities in the last two years with the launch of the HeartOne website. Through the HeartOne portal, members can access a wide range of educational material including e-journals, case and image files, video and audio lectures and specific learning modules. The HeartOne portal tracks an individual member's use of learning resources, answers to formative assessment questions and activities. In addition, the portal allows members to record their CPD activties and to produce a monthly and annual summary of activities for reporting purposes. The HeartOne platform is accessed at www.heartone.com.au.

The CSANZ recognises the central importance of continuous quality improvement for all practitioners, and in particular the need for systems and practices which improve patient safety and support optimal management outcomes for all patients.

The CSANZ has made several important initiatives in recent years in support of quality of practice.

Chronically Implanted Pacemaker Lead Extraction

The removal of chronically implanted pacemaker leads is a difficult procedure, which carries some significant risk to the patient. After discussion with the Dept of Health and Ageing and consultation with expert groups within the profession, a process was established for the review of the training and experience of practitioners wishing to undertake lead extraction.The process involved the setting of criteria

for training and experience in lead extraction, the monitoring of patient outcomes and a system for review of experience and accreditation of practitioners.

This initiative was supported by the membership of the CSANZ as an important step for promoting quality of practice. The Lead Extraction Review Committee meets regularly to assess applications and review outcomes logged by individual practitioners and will give feedback to practitioners about performance and recommendations about continuance of accreditation. The criteria for accreditation and recertification in extraction of chronically implanted pacemaker leads are published at www.csanz.edu.au/resources.

Australian and New Zealand Cardiac Device Advisory and Complications Committee

In 2012 the CSANZ established the Australian and New Zealand Cardiac Device Advisory and Complications Committee (ANZCDACC) for the purposes of assisting physicians who implant and follow-up cardiac devices to manage device advisories and monitor outcomes. This includes advisories related to pacemaker and implantable cardioverter defibrillator generators, pacing and defibrillation leads, implantable loop recorders and programmers/remote follow-up components. It also serves as an official liaison for physicians between the governmental authorities concerned in Australia (Therapeutic Goods and Administration) and New Zealand (Medsafe), patients, the public and industry.

The establishment of ANZDACC by CSANZ has been a key initiative. Important features are establishment of the principle of clinician-led review and reporting of device outcomes, description of severity levels of device malfunction and definition of important response times as well as establishment of an approach for notification of clinicians and other relevant stakeholders, including the Therapeutic Goods Administration.

AUSTRALASIAN CARDIAC OUTCOMES REGISTRY (ACOR)

One of the key elements of modern cardiology practice is coronary angiography with associated interventional procedures for coronary revascularisation. In parallel, there have been major advances in electrophysiological catheter studies and interventions. Most recently, catheter-based structural interventions, such as percutaneous valve replacement, have been increasingly important. These invasive procedures require considerable skill by the operating practitioner, which requires appropriate sub-specialty training and continuing experience. As these invasive procedures can carry significant risk to the patient, there has been an increasing consensus on the need for a system for monitoring outcomes after interventional cardiac procedures and for reporting these outcomes against benchmarked performance standards.

The CSANZ therefore supported the establishment of a new corporate entity, Australasian Cardiac Outcomes Registry (ACOR) which was tasked with implementation and operation of a national registry of outcomes after interventional cardiac procedures, including coronary procedures, electrophysiological procedures and structural procedures. The development and conduct of the clinical quality registers in cardiovascular medicine is to adhere to the *Strategic Principles for a National Approach to Australian Clinical Quality Registries.*

Australasian Cardiac Procedures Registry

In 2012, ACOR conducted a national competitive tender for the establishment of a national Clinical Quality Register for Cardiac Procedural Outcomes for Australia and New Zealand, with reference to patient outcomes after coronary interventional, structural cardiac, and electrophysiologic procedures and devices. The group considered by ACOR to be best suited to the conduct of this registry was the South Australian Health and Medical Research Institute (SAHMRI).

The evaluation criteria for the tender included capacity to establish and maintain the registry; security and reliability of data collection and storage; capacity for data analysis and reporting, including outlier identification with appropriate clinical risk stratification; excellence of communication with clinical members and professional leaders and value for money. These evaluation criteria reflected the AHMRC endorsed Strategic and Operating Principles for Australian Clinical Quality Registers.

The necessary data-sets and supporting materials have been developed by clinical leaders in relevant areas in collaboration with the SAHMRI team. At the same time, the relevant Client Service Agreements for participating hospitals have been developed. The National Cardiac Procedural Outcomes Register for Coronary Interventions commenced operation in 2015.

Specifically, ACOR is responsible for clinician and hospital engagement, recruitment of craft group leaders, preparation of information material and Client Service Agreements and liaison with stakeholders and oversight of reporting. Specifically, SAHMRI is responsible for registry dataset design, data entry and management, including on-line tools, data analysis and risk stratification and support to participating clinicians and hospitals.