Expert Advisory Group on revalidation

Interim report

The proposed approach to support medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine

August 2016

Executive summary

The fundamental purpose of revalidation is to ensure public safety in healthcare. The Medical Board of Australia's Expert Advisory Group (EAG) has identified 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, and
2. proactively identifying doctors who are either performing poorly or are at risk of performing poorly, assessing their performance and if necessary, supporting their remediation.

An integrated approach will be most effective. CPD alone, however rigorous, may not identify the practitioner who may be putting the public at risk. A regulatory approach, however thorough, cannot reliably, single-handedly improve the quality of care provided by most competent doctors.

This report proposes a 'two by two' approach to revalidation in Australia:

- Two parts: strengthened CPD and proactive identification and assessment of 'at-risk' and poorly performing practitioners
- Two steps: engage and collaborate in 2016 + recommend an approach to pilot in 2017.

This 'two by two' model represents evolution, not revolution, in the requirements for doctors to make sure they provide safe care to patients throughout their working lives.

The two parts:

1. **Strengthened CPD**: Evidence-based approaches to CPD best drive practice improvement and better patient healthcare outcomes. Strengthened CPD, developed in consultation with the profession and the community, is a recommended pillar for revalidation in Australia.
2. **Identifying and assessing at-risk and poorly performing practitioners**: A small proportion of doctors in all countries is not performing to expected standards at any one time, or over time. Another group of practitioners is at risk of poor performance. Developing accurate and reliable ways to identify practitioners at risk of poor performance and remediating them early is critical, with considerable transformative potential to improve patient safety. It is equally critical to identify, assess and ensure there is effective remediation for practitioners who are already performing poorly.

The two steps:

- **August to November 2016**: With the Medical Board of Australia (the Board), engage and work with the profession and the community to discuss options to:
  - strengthen existing evidence-based approaches to CPD that best drive practice improvement and better patient healthcare outcomes, and
  - proactively identify at-risk practitioners and poorly performing doctors, to enable early intervention and tailored quality improvement.
- **By mid-2017**: Review what we have learned in discussions with the profession and the community and propose to the Board a more detailed approach for pilot, or as appropriate, rollout in Australia.

Guiding principles

Consistent with the intent of the Medical Board of Australia, the EAG recommends the following guiding principles will apply to all potential approaches:

- 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 improvements should be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.

Part one: Strengthened CPD

CPD: a snapshot of the profession

Australia's 100,000-plus medical practitioners can be clustered into five broad groups in relation to CPD.

The groups are medical practitioners with:

a. specialist registration who participate in structured college CPD programs

b. general registration who participate in a relevant structured college CPD program

c. specialist registration who undertake self-directed CPD activities that meet college requirements

d. general registration who undertake self-directed CPD activities, and

e. limited, provisional or general registration, who are under supervision, in supervised practice or training programs.

The EAG does not have information about the actual distribution of practitioners within these groups. Current registration data indicate a significant proportion (around 55%) of medical practitioners hold specialist registration and are therefore required to meet the requirements of a specialist medical college CPD program. The EAG would like to seek more information about the actual distribution, through discussion with stakeholders.

Under current Australian regulatory requirements, all individuals in 'group e', i.e. those in training or under supervision, will progress to one of categories a – d over a fixed period.

The EAG believes that the structured training and supervision in place for 'group e' is adequate to protect patients, and to monitor and as needed to address the performance of individual practitioners. This interim report therefore focuses on options to strengthen CPD requirements for practitioners in groups a – d, to improve public safety in healthcare.

Strengthened CPD

Strengthened CPD, developed in consultation with the profession and the community, is a central focus for revalidation in Australia.

CPD is continuing to evolve. Led by the profession, in consultation with the community, 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 colleges, all proposed changes to strengthen CPD must apply and be accessible to all registered medical practitioners.

To achieve this, the EAG is proposing to strengthen CPD by:

1. **Applying a set of guiding principles to shape all CPD for medical practitioners in Australia. These guiding principles are:**

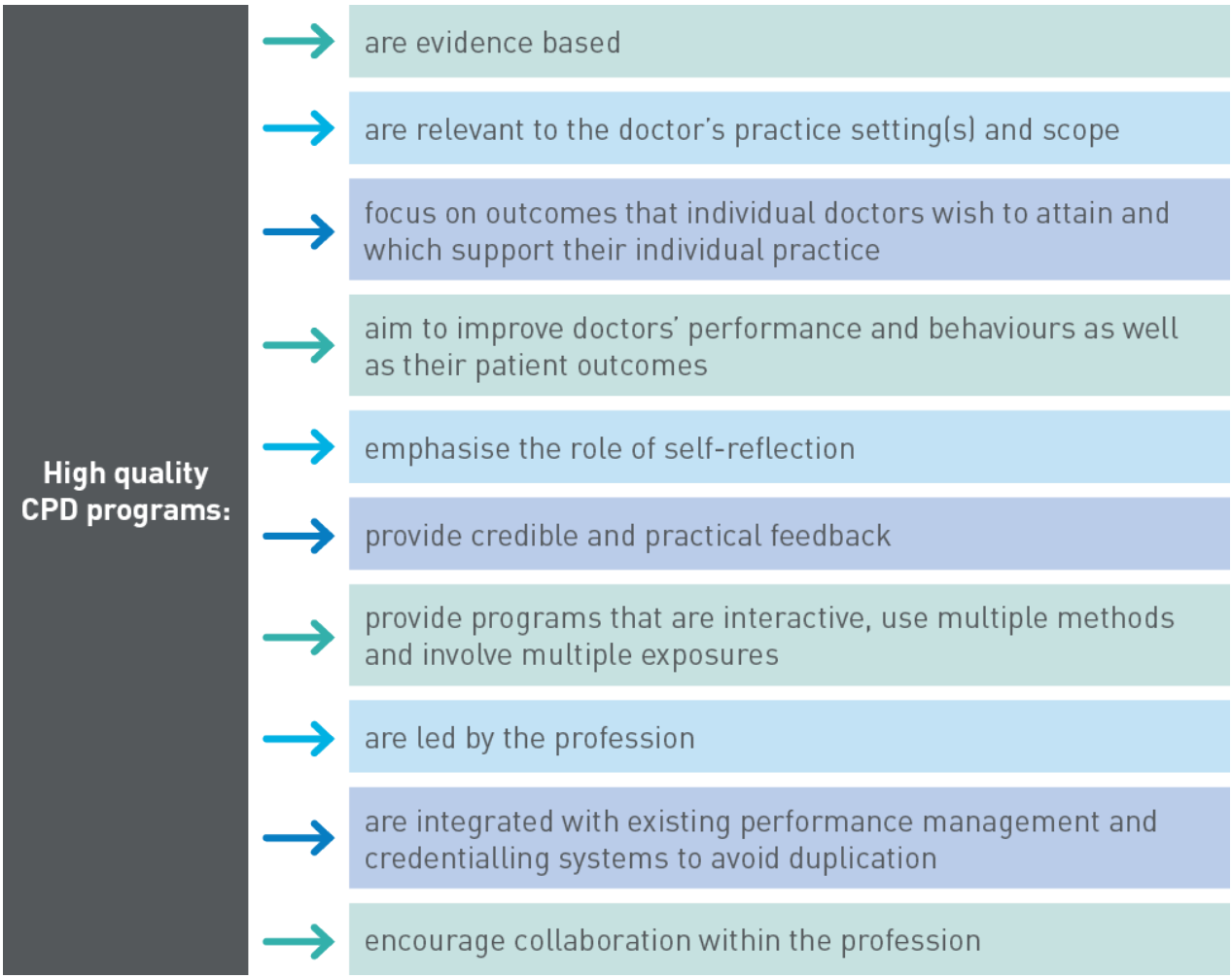

Figure 1: Guiding principles for CPD

2. **Ensuring medical practitioners in clinical practice participate in three core types of CPD, with activities prioritised to strengthen individual performance. All recognised CPD activities would be evidence-based and involve performance review, patient outcome measurement and validated educational activities. CPD would be broadly based, to improve all aspects of practice.**

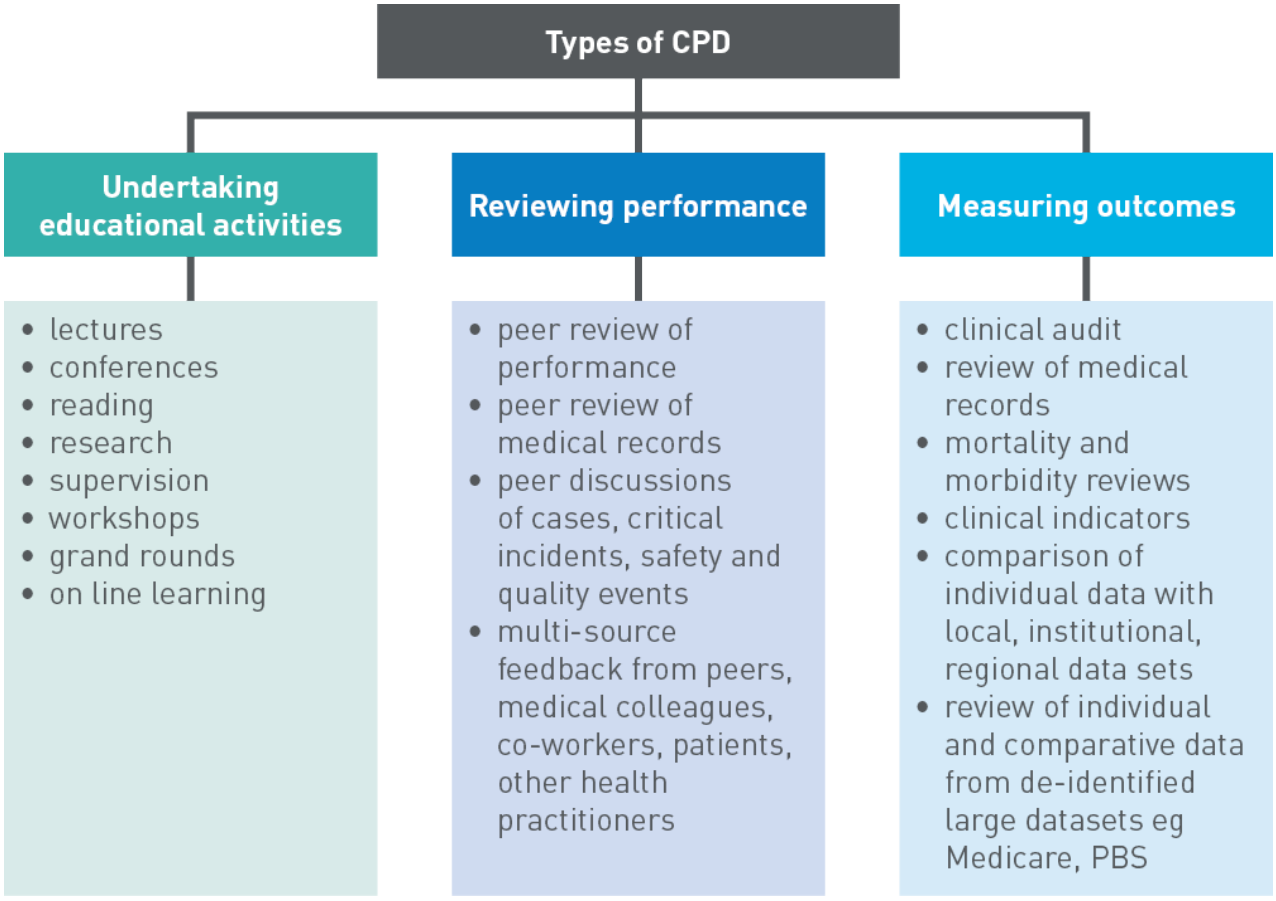

Figure 2: Types of CPD

Part two: Identifying and assessing practitioners at risk of poor performance and poorly performing practitioners

A small proportion of doctors in all countries is not performing to expected standards at any one time, or over time. Many practitioners found to be under-performing self-remediate or return to safe practice with local support. This is the preferred approach.

Another group of practitioners, however, is at risk of continued poor performance. To improve patient safety, improve practitioner performance and reduce the adverse impacts of patient complaints on complainants and doctors, it is critical to develop accurate and reliable indicators to identify at-risk and poorly performing practitioners, and when necessary, to intervene early with improved remediation processes.

It is equally critical to improve our ability to identify, assess and effectively remediate practitioners who are poorly performing, including those who are the subject of multiple complaints or notifications and are already at a high predicted risk of continued poor performance.

We do not know enough about the extent of 'at-risk' and poorly performing medical practitioners among those undertaking different types of CPD programs in Australia. The EAG proposes that strategies to effectively identify and assess 'at-risk' and poorly performing practitioners should apply across all categories.

Practitioners at risk of poor performance

Identifying risk factors

Prevention is better than cure. Developing indicators to identify 'at-risk' practitioners and being clear about actions to effectively assess them is critical, so effective interventions can follow.

The strongest risk factors associated with an increasing regulatory risk profile that have been identified and replicated both nationally and internationally are:

- age (from 35 years, increasing into middle and older age)
- male gender
- number of prior complaints, and
- time since last prior complaint.

Additional individual risk factors found in certain studies include:

- primary medical qualification acquired in some countries of origin
- specialty
- lack of response to feedback
- unrecognised cognitive impairment
- practising in isolation from peers or outside an organisation's structured clinical governance system
- low levels of high-quality CPD activities, and
- change in scope of practice.

Based on available evidence, the EAG believes that the time has come to deepen our understanding of factors that most reliably and practicably indicate practitioners at risk of poor performance that are relevant to medical practice in Australia.

We propose that there is now enough evidence to trigger discussion and draw on insights available about how various risk factors might be used to proactively identify practitioners at risk of poor performance in the Australian healthcare environment. Doing this could enable early intervention to protect the public and individual doctors from ongoing risk and improve the performance of these doctors. Deepening the understanding of the risk profiles of doctors who are already the subject of complaints or notifications using existing regulatory databases will provide a more accurate picture of risk indicators, improve ways to predict risk, and suggest the optimal timing and avenues for intervention.

Assessing individuals

Having identified the cohorts, or groups of practitioners at most risk of poor performance, it is important to then assess the identified individuals to determine whether and how the individuals actually pose a risk to public safety. Not all individuals in at-risk groups will be underperforming. Some practitioners who are identified as underperforming will return to safe practice simply through the process of being assessed and receiving feedback.

Robust early detection and remediation processes are anticipatory and preventive. They should be non-punitive, individualised and educational, designed to return the doctor to safe practice as soon as possible. The level of assessment of at-risk practitioners should be proportionate to the level of risk, consistent with the guiding principles. Examination-style assessment will not be effective in this task.

Tiered assessment

The EAG supports a tiered approach to assessment of performance, scaled to match the level of potential risk. A tiered, multi-faceted assessment strategy could start with multi-source feedback for low-risk cases, escalating through peer review and feedback processes, to more thorough in-situ evaluation to fully determine the nature of serious underperformance in doctors as required by the regulator. Cost-effective, early interventions should escalate only as needed.

1. Specialty-specific multi-source feedback (MSF) is the recommended starting point to assess whether practitioners in at-risk groups are performing safely, or are underperforming, or are poorly performing. The available evidence indicates that it is an effective and practical performance appraisal tool. MSF gained from colleagues, co-workers, and patients may provide a practical, cost-effective and efficient pathway for the early detection of doctors at risk of poor performance. It is consistent with the guiding principles outlined on page seven. Used effectively in CPD programs, it has been shown to identify gaps in both clinical and professional performance, to trigger self-reflection and to improve practitioner performance. It has also been used to help identify doctors who are not performing to accepted standards.
2. The next level of assessment – for doctors who may pose more serious risk – involves more intensive peer-mediated processes. This could include peer review of medical records, peer review of performance in practice, and/or facilitated feedback based on practice or outcomes data.
3. The highest level of assessment would align with extensive performance assessment, as can be mandated by regulators.

Comparing the results of MSF from 'at-risk groups' with results of MSF from practitioners not in at-risk categories will be important for benchmarking.

Poorly performing practitioners: identifying, assessing and remediating individuals

International research indicates that about six per cent of medical practitioners are poorly performing at any one time. No Australian research has yet reliably identified how many medical practitioners in Australia fall into this category. Future Australia-specific research should confirm this number. In the meantime, the EAG believes that action is required to identify, assess and where possible remediate all of these practitioners, in the public interest.

Responsibility for identifying and remediating under-performing and poorly performing practitioners in Australia needs further development and consensus.

Figure 3 depicts groups of medical practitioners in Australia in terms of their selected CPD framework and their practice context and the potential responsibility for supporting and managing remediation.

	Practice context	
CPD framework	Practising in an organisation with defined clinical governance structures	Practising outside a defined clinical governance structure
Specialist college CPD	**Shared – college and employer**	**College**
Outside a specialist college (self-directed CPD)	**Employer**	**?**

Figure 3: Potential responsibility for managing remediation

It is important to define accountabilities and responsibilities for identifying and acting on under or poorly performing practitioners. This would enable us to better understand and agree on which stakeholders have a role in assessment and a responsibility to act on the results of that assessment to improve or remediate performance. Other related issues raised include:

- the thresholds for reporting practitioners to regulators in the context of poor performance
- who is responsible for supporting and assisting the remediation of identified under-performers who are not referred to the regulator because they do not meet the threshold for regulatory referral
- how under or poor performance among practitioners who are outside colleges and work outside organisations with robust clinical governance structures are best identified and managed, and
- the barriers to information-sharing that, if cleared, would enable effective identification, remediation or other action to promote public safety.

Stakeholders who may have knowledge or concern about poorly performing practitioners are likely to include:

- patients
- peers
- colleagues and co-workers
- employers
- specialist colleges
- jurisdictions (health departments)
- insurers
- coroners
- other agencies with information that could identify 'outliers' (e.g. Medicare, agencies monitoring prescribing, etc.), and
- regulators and health complaints entities.

The role of the Medical Board of Australia and AHPRA and others in New South Wales and Queensland's co-regulatory jurisdictions is to manage risk to patients, within the framework of the National Law. The Board has clear powers to act, including by limiting the registration and therefore the practice of individuals, when the risk to patients is high. The Board's processes for assessing performance in specific cases are structured and systematised. The EAG is excluding the regulatory performance management of poorly performing doctors from its focus, and is focused instead on the roles and responsibilities of all health sector stakeholders for proactively identifying, assessing and managing the remediation of 'at-risk' and poorly performing practitioners to focus and drive prevention.

The EAG believes it is essential to develop a clear and shared understanding of the roles and responsibilities of the relevant stakeholders in identifying poor performers and acting jointly on that knowledge to better protect patients. It is important to create an integrated system in which health sector stakeholders with existing concerns about or knowledge of practitioners who are performing poorly clearly understand their responsibilities:

- to act on the knowledge or concerns that they have
- for information-sharing in the public interest, and
- to ensure effective intervention to support remediation or action to protect public safety.

Remediation

Remediation should also be tailored to the nature and level of the risk. The current knowledge-base about remediation processes and outcomes is not as well developed as knowledge about performance assessment processes, and is fragmented and diverse. Some studies have been conducted as stand-alone studies in areas of researcher or organisational interest. There is little information about long-term outcomes of remediation on doctors' subsequent performance. The lack of robust processes surrounding optimal remediation was recognised in the UK, with the formation of a Steering Committee on Remediation to assist thinking for revalidation. In Australia, equally, these weaknesses should be addressed. Continuing research to confirm the efficacy of remedial interventions will be needed.

Next steps

The EAG has been asked to advise on ways to develop an approach to revalidation that is tailored to the Australian environment and that will help make sure that the trust and confidence the community has in the medical profession is well founded. Ongoing evaluation of these approaches will be necessary to make sure that future strategies remain feasible, contemporary and in line with changes in the environment and the profession.

We look forward to discussion with stakeholders in the community and the profession about the approaches we have proposed in this interim report. All feedback and discussion will inform our final report and recommendations for action.