Options for revalidation in Australia

Discussion paper

August 2016

Summary

The Medical Board of Australia (the Board) has published the interim report of its Expert Advisory Group (EAG) on revalidation and wants to promote stakeholder discussion, debate and feedback on the EAG's proposed approach.

The Board is committed to developing a process that supports medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine. The Board has adopted the term 'revalidation' for this process.

The Board appointed the EAG to provide it with technical expert advice on revalidation. In particular, the Board asked the EAG to develop one or more models for revalidation in Australia and to provide advice on how to pilot the models so that they can be evaluated for effectiveness, feasibility and acceptability.

The EAG's interim report proposes an integrated approach that has two components:

1. maintaining and enhancing the performance of all medical practitioners through effective continuing professional development (CPD) 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.

The interim report provides the evidence and the rationale for the proposed approach. Before progressing further, the EAG and the Board are interested in the views of stakeholders.

The final report will be submitted in 2017 and will include recommendations for change, including proposal/s for pilots of various key processes.

Consulting on the proposed approach

The Board is seeking to consult on the EAG's proposed approach to revalidation in Australia. In addition to general feedback, the Board is interested in stakeholders' feedback on specific questions about the approach.

Feedback can be provided in a number of ways by close of business on **30 November 2016**:

- contribute to the online discussion on the Board's website
- take a short survey to provide your views on the approach
- send a written submission by email, marked: 'Revalidation' to medboardconsultation@ahpra.gov.au
- send a written submission by mail, addressed to the Executive Officer, Medical, AHPRA, GPO Box 9958, Melbourne 3001

Submissions for publication on the Board's website should be sent in Word format or equivalent.[1]

Publication of submissions

The Board publishes submissions at its discretion.

The Board generally publishes submissions on its website to encourage discussion and inform the community and stakeholders. Please advise us if you do not want your submission published.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally-identifying information from submissions, including contact details.

[1] We aim to publish documents in accessible formats (such as word files) to meet international website accessibility guidelines. Therefore, while you are welcome to supply a PDF file of your feedback, we ask that you also provide a text or word file. More information about this is available at www.ahpra.gov.au/About-AHPRA/Accessibility.aspx

The views expressed in the submissions are those of the individuals or organisations who submit them and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission, or want us to treat all or part of it as confidential.

Published submissions will include the names of the individuals and/or the organisations that made the submission, unless confidentiality is requested.

Background

The Medical Board is responsible for regulating medical practitioners in the public interest. It is committed to developing a process that supports medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine. The Board has adopted the term ‘revalidation’ for this process.

Since 2012 the Board has consulted with the medical profession and the community about options for revalidation in Australia and has commissioned international research. In late 2015 it appointed an Expert Advisory Group (EAG) to provide it with technical expert advice on revalidation. In particular, the Board asked the EAG to develop one or more models for revalidation in Australia and to provide advice on how to pilot the models so that they can be evaluated for effectiveness, feasibility and acceptability.

The EAG has considered international evidence on revalidation as well as relevant Australian data and has described a preliminary conceptual approach for the development of a revalidation system in the Australian context.

The Board is releasing the EAG’s interim report to guide discussion, debate and generate feedback from all interested stakeholders. All feedback received will be considered by the EAG who is expected to provide a final report to the Medical Board by mid-2017.

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. They are complementary but treated separately in the report, with different aims and processes. The EAG concluded that CPD alone, however rigorous, may not identify the medical 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.

What it will mean for the majority of medical practitioners

For most practitioners who are already doing effective CPD, this two-part process will not have a significant impact on their CPD. Some practitioners would need to change the focus of their CPD to include performance review, outcome measurement and validated educational activities. For others who are identified as being at risk of poor performance, there will be further screening and assessment to identify whether or not they practising safely or whether they would benefit from remediation.

Questions for discussion

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?
2. Are there other approaches that could feasibly achieve these aims?
3. What are the barriers to implementation and gaps that will need to be addressed for the proposed approach?

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.

Questions for discussion

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?

Part one:
Strengthened continuing professional development

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.

Questions for discussion

5. How can evidence-based strengthened CPD be achieved?
6. Who should be involved in strengthening CPD and what are their roles?
7. Are there any unintended consequences of this approach?
8. How can we collaborate with employers and other agencies involved in systems which support and assure safe practice to minimise duplication of effort?

Guiding principles for CPD

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.

The guiding principles are summarised at Figure 1:

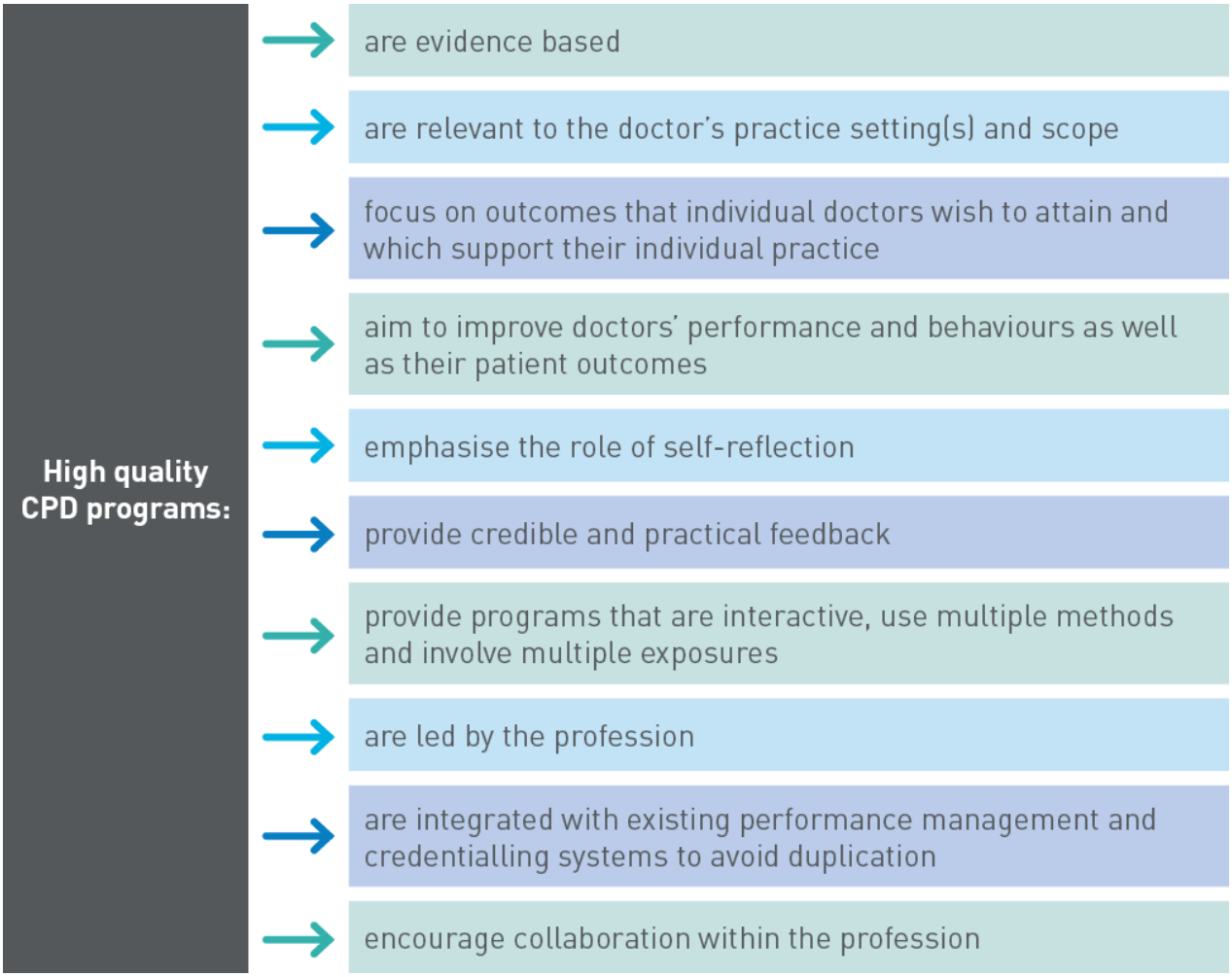

Figure 1: High quality CPD programs

Questions for discussion

9. Is each of these principles relevant and appropriate?

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

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.

The core types of CPD and examples are summarised at Figure 2.

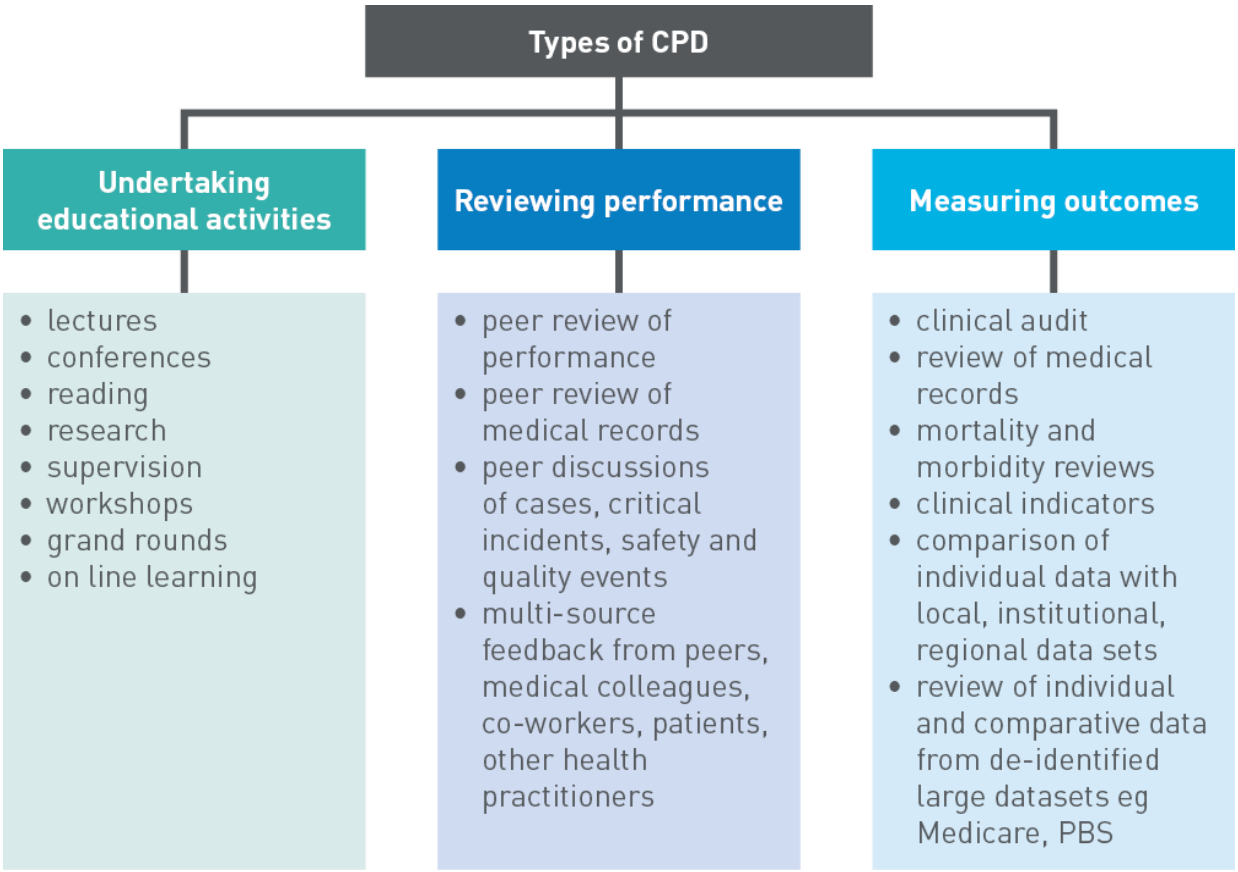

Figure 2: Types of CPD

Questions for discussion

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?

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?

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?

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.

Identifying 'at-risk' medical practitioners

The EAG states that 'prevention is better than cure'. It is necessary to develop indicators to identify 'at-risk' medical practitioners early and to be clear about actions to assess them so effective interventions can follow if necessary.

The EAG presents research that 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.

Questions for discussion

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

Assessing: scaling the assessment to the level of risk

Having used the risk factor indicators above to identify medical practitioners who are at most risk of performing poorly, the EAG argues that it is important to then assess the identified individuals to determine if, and then how, they actually pose a risk to public safety.

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.

Tier 1

The EAG recommends consideration of specialty-specific multi-source feedback (MSF) as the starting point to assess whether medical practitioners in “at-risk” groups are performing safely, are under-performing, or are performing poorly. Using the input of peers, colleagues, co-workers and patients, MSF can provide a practical, cost effective and efficient pathway for the early detection of medical practitioners at risk of poor performance. The EAG notes MSF is already conducted as part of a number of college CPD programs and employee performance appraisal processes.

The EAG states that the MSF should be specialty specific and will require comparative or ‘benchmark’ data from peers who are not deemed to be at-risk.

Tier 2

The EAG proposes that the next level of assessment – for medical practitioners who may pose more serious risk would involve 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.

Tier 3

The highest level of assessment would align with extensive performance assessment, as can be mandated by regulators.

Questions for discussion

17. What do you think about the proposed options for a tiered assessment?
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?
19. If MSF is to be used, how can Australian benchmarks be developed? What are appropriate sources of comparative data?

Poorly performing medical practitioners

While the individual medical practitioner must take responsibility for their remediation, the EAG reports that responsibility for identifying, assessing and supporting remediation of underperforming and poorly performing medical 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 supporting and managing remediation

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.

Questions for discussion

20. Which stakeholders have a role in identifying, assessing and supporting remediation of poorly performing medical practitioners, or those at-risk of poor performance?
21. What is each stakeholder's responsibility to act on the results of that assessment to address medical practitioners' performance?
22. What barriers are there for stakeholders to share information about the performance of medical practitioners? How can these barriers be overcome?
23. What are your views about the threshold for reporting poorly performing medical practitioners to the Medical Board?
24. Who should be responsible for supporting remediation of identified under-performers who do not meet the threshold for referral to the Medical Board?
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?

Attachments

Revalidation Expert Advisory Group Interim report