General Enquiries
and Client Service
P 1800 777 156
F 1800 839 284

Claims and Legal
Services
P 1800 839 280
F 1800 839 281

www.miga.com.au
miga@miga.com.au

Postal Address
GPO Box 2048, Adelaide
South Australia 5001

30 November 2016

Dr Jo Katsouris
Executive Officer, Medical
AHPRA
GPO Box 9958
MELBOURNE VIC 3001

Via email and post: medboardconsultation@ahpra.gov.au

Dear Dr Katsouris

MIGA Submission to Medical Board of Australia consultation on Revalidation

MIGA welcomes the opportunity to provide this submission in relation to the Board's consultation on Revalidation. We have maintained a significant interest in the issue of revalidation, particularly through participation in Board forums and our own discussion forums.

As a medical defence organisation and indemnity insurer with a significant national footprint, MIGA is well-placed to comment on the merits of revalidation processes and issues which need to be considered. Its roles in advising and assisting its members through disciplinary and performance processes, and providing risk management and education to the medical profession, give it an important insight into the key issues around revalidation processes. Its focus on doctors' health means it can see how these processes may affect the health and well-being of practitioners.

MIGA's position generally

MIGA's position on the Expert Advisory Group's (**EAG**) proposals is:

- it supports appropriate processes to ensure medical practitioners maintain and enhance their professional skills and knowledge, and remain fit to practise medicine

- it is important there is a strong, cogent case that a proposed process is a worthwhile and necessary addition to existing frameworks for ongoing practitioner training and protection of the public – this is best done through a focus on need, quality and value, as opposed to process, quantity and unclear aspirations

- to demonstrate the value of an appropriate process, considerable work will need to be done to ensure that the medical profession understands, and has confidence in, such a process - an important first step is finding an alternative term to 'revalidation' to describe any process, particularly given its inherent association with the United Kingdom process of the same name, which the Board and EAG have clearly distanced themselves from

- considerable work is required to determine what an appropriate process looks like in practice, particularly for different medical specialties and career stages, and who is responsible for different aspects of the process

- there needs to be careful review of what is already in place which can either be incorporated in, or used as a model for, an appropriate process, such as existing College training frameworks, and hospital-based accreditation and clinical governance mechanisms

- the appropriate process is tailored to individual contexts, building on and enhancing both existing continuing professional development (**CPD**), and other peer review and accreditation processes

- MIGA supports an improved system of monitoring and assessment of 'at risk' practitioners, but would like to see more work undertaken on what constitutes poor practice in different contexts, appropriate forms of remediation and when a regulator would need to become involved

- there is a need for an incremental approach, involving

    - close examination of existing CPD and risk identification systems throughout Australia

    - determination of whether augmentation of existing systems (as outlined in response to question 2 below) would be sufficient to ensure continuing high standards of health care

    - if further steps are necessary, consideration of a staged / piloted introduction of appropriate CPD and risk identification initiatives, which can then be tested for value and efficacy before any wider implementation - it would be preferable to focus on CPD initiatives first, before determining if and where risk screening processes are required

- consideration needs to be given to appropriate support mechanisms for practitioners who have been identified at risk of, or who are, performing poorly, given the inevitable effect such processes may have on their health – this will need to build on existing Doctors' Health initiatives, such as those provided by various Australian Medical Associations and by medical defence organisations such as MIGA for their members

MIGA welcomes the careful consideration given by the EAG to many of these issues, and looks forward to further consideration and consultation around them.

MIGA responds to the questions raised in the Board's Paper, *Options for Revalidation in Australia – Discussion Paper* and raises further issues for consideration below.

Proposed approach – what will it mean for the majority of medical practitioners?

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 practitioners back to safe practice?

The proposed approach is a potentially appropriate process to maintain necessary standards of care and performance by medical practitioners, and to identify either risk or reality of poor performance, attempting remediation wherever possible.

MIGA would first like to see options for augmentation of existing systems explored (as outlined in response to question 2 below) before the more significant changes contemplated by the proposed approach are considered.

MIGA has some reservations about the proposed approach, particularly in terms of possible underlying assumptions and how it may look in practice.

(a) Concerns about underlying assumptions

MIGA would be concerned if there is an underlying assumption, as could be suggested by question 1, that the performance of all medical practitioners needs to be improved.

If the question merely reflects a view that practitioners should, and will, continue to learn and develop their skills throughout their careers, MIGA endorses this.

MIGA has considerable difficulty with any assumption that a need for revalidation arises out of a broad problem with standards of care in the Australian medical profession. The EAG interim report reveals that only a small proportion of Australia medical practitioners are not performing to expected standards.

MIGA endorses the EAG's view about the "*fundamental premise*" of CPD for medical practitioners, namely to ensure they maintain an enhanced clinical knowledge, skills and professional behaviours throughout their working lives.

It is critical to emphasise that an appropriate process reflects expected career-long learning by all medical practitioners, and not any assumptions about any supposed broader issues of inadequate performance amongst the medical profession.

(b) Concerns about identification of 'at risk' practitioners

MIGA has some reservations about what may be involved in proactively identifying medical practitioners at risk of performing poorly.

It supports appropriate methods for assessing poorly performing practitioners and, wherever possible, taking steps to assist them in improving their practice.

However, it has some reservations about a number of the 'strongest' and 'additional' risk factors identified in the EAG's interim report.

There are Australian and international studies which suggest the factors listed are potential risk factors. However, the evidence base for the use of a number of them in identifying medical practitioners who may be at risk of poor performance is both insufficient and unconvincing.

There is considerable value in recent Australian studies on these issues. However, they are essentially quantitative analyses of complaints to regulators, identifying potential risk via categorisation of nature of complaints into various issues. They are not broader, qualitative analyses of potential factors which may lead to risks of poor performance by medical practitioners. They are only one aspect of understanding potential risk factors around poor performance. Complaint categorisation is useful, but the triggers and substance of complaints are inherently subjective. There is no qualitative analysis of the comparative merits of individual complaints. Categorisation can provide clues about risk factors, but their comparative value is far greater for looking at the circumstances of the individual medical practitioner, rather than as conclusive evidence about potential risk factors for the medical profession more broadly.

Before settling on risk factors to use in an appropriate process, considerably more work is required, utilising different perspectives from outside the complaint setting. This involves:

- further engagement with specialist colleges and associations, government health departments, and other entities which can deal with issues of clinical standards and performance

- further thorough and well-designed studies of both professional performance outside the complaint context, and how this relates to those already undertaken in the complaint context

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

There is no clear reason why an augmentation of the status quo could not continue to ensure public safety in health care. This would involve:

- continuing with CPD overseen by colleges, but investigating how they can ensure CPD continues to be relevant and effective for practitioners who have completed specialist training

- investigating what information on CPD undertaken by individual medical practitioners is most useful for the Board so it can be satisfied about a practitioner's professional performance

- investigating alternative methods for overseeing relevant and effective CPD for those in the 'vocational', ie outside college, contexts

- better education of the profession around mandatory notification obligations – in particular, practitioners often find it difficult to determine whether concerns they have around a colleague's practice represent a significant departure from expected standards

- better use of complaints to regulators and the disciplinary system to identify proactively any broader issues emerging from individual complaints

If these steps prove to be insufficient, consideration could then be given to:

- how local systems (whether employers, peer groups, hospitals or other practice contexts) and colleges can more effectively identify practitioners at risk of poor performance, or performing poorly – a focus on best practice methods of supervisor and peer assessment could provide the critical determinant of whether a practitioner is performing appropriately

- introducing a separate system of identifying practitioners at risk of poor performance, or performing poorly, who are outside any college or local setting which can fulfil this function

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

MIGA sees the following barriers to, and gaps in, the proposed approach:

- **uncertain responsibilities** – determining the precise responsibilities for providing, completing and ensuring completion of strengthened CPD, and proactive identification of those at risk of poor performance and subsequent responses – what are to be the respective roles, particularly around risk screening, of colleges, regulators, employers, hospitals and other stakeholders?

- **communication between stakeholders** – given the potential number of bodies involved in any process, it is imperative to have open, regular and quality communication between those bodies

- **what is the relationship between strengthened CPD and proactive identification of doctors at risk of poor performance, or already performing poorly?** Will there be feedback mechanisms from strengthened CPD which lead into proactive identification processes? If there are, MIGA has reservations about this, given uncertainty around oversight and control of information conveyed, where it would go and what it could lead to

- **resourcing and funding** – who will bear the significant funding and service provision responsibilities? Even if there is increased reliance on private providers for strengthened CPD, other bodies will need to undertake additional oversight responsibilities - the costs associated with proactive identification processes are likely to be considerable

- **need for broad stakeholder support** – without a broad cross-section of the medical profession supporting both strengthened CPD and proactive identification processes, they are unlikely to work effectively – instead, it may leave a system of mere "*paper compliance*", offering no meaningful contribution to professional practice

- **risk of focus on process over quality** – both strengthened CPD and proactive risk identification processes are likely to lead to the development of detailed administrative and oversight processes, which offer the inevitable risk of becoming more about "*tick a box*" compliance instead of meaningful improvement in health care standards

- **developing appropriate measurements for proactive identification processes beyond mere use of screening risk factors**

- **increased workloads for all involved**, particularly medical practitioners subject to these regimes and other bodies administering them, such as regulators, colleges, employers, hospitals and other stakeholders

- **risks of bullying and harassment arising out of proactive identification processes –** it is imperative to ensure performance management from a 'human resources' or 'corporate' perspective does not mix inappropriately with issues of poor clinical or professional performance

Guiding principles

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?

Yes, MIGA agrees with the guiding principles of "*smart and not harder*", "*integration with existing systems"* and "*relevant, practical and proportionate*", but proposes the following additional guiding principles:

- **reasonable requirement** – is there a reasonable and demonstrated need for the particular approach?
- **fairness** – recognising differences in age, backgrounds, training and practising contexts
- **achieving stakeholder commitment** – without support by a wide cross-section of the medical profession, any scheme is unlikely to make a meaningful contribution to practitioner performance, professional standards and patient safety

Part 1 - Strengthened CPD

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

There will need to be a close examination of existing CPD frameworks and delivery, with an emphasis on determining effectiveness, efficiency and quality, followed by determination of 'gaps' in current offerings and what must be done to fill them.

Strengthened CPD must be focused on individual scopes of practice, particularly tailored to varying levels of seniority and experience, to avoid reducing CPD to the "*lowest common denominator*".

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

Regulators, professional colleges and associations, employers, hospitals and other health care practice settings are the primary contributors to strengthened CPD processes.

Professional indemnity insurers such as MIGA and other bodies who provide considerable amounts of risk management, education and accreditation also have a role to play.

7. Are there any unintended consequences of this approach?

Strengthened CPD could become "*broad brush*", based around asserted adherence to general principles as opposed to effective and quality contribution to an individual practitioner's learning and development.

There must be an appropriate balance between individual practitioner CPD self-selection, and meaningful general and specific standards for expected CPD, focused on individual scope of practice. An imbalance may render this approach ineffective.

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

Regulators, colleges, associations, employers, hospitals, other bodies providing health care and professional indemnity insurers such as MIGA need to work together to understand the professional needs of practitioners, what is already on offer and what might need to be provided.

There is an opportunity for these stakeholders to take responsibility in appropriate areas for developing targeted education based on regulator, government and college data around particular issues and risks.

There is also a need for regular and meaningful dialogue between those bodies in relation to strengthened CPD.

Guiding principles for CPD

9. Is each of these principles relevant and appropriate?

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

MIGA agrees with the guiding principles for higher quality CPD programs, subject to the following further comments:

- **aim to improve doctors' performance and behaviours as well as their patient outcomes** – what is meant by performance, behaviours and patient outcomes needs to be considered further, particularly the extent to which these are objectively measurable, how they are adapted to individual practice contexts and are measured against peers

- **emphasise the role of self-reflection** – so long as this is meaningful self-reflection, not standardised self-reflection based on generalised criteria used throughout the profession

Three core types of CPD

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

At a general level, the proposed model offers a reasonable basis for strengthened CPD. MIGA sees the following potential issues:

- what is meant by "*evidence-based*" CPD, how would it be developed and how would it be assessed – there is a need to ensure that valuable processes, such as informal peer interaction, are not devalued

- time and resourcing issues relating to reviewing of performance

- funding issues relating to measuring outcomes

- ensuring that all steps are focused on quality, not quantity

- educating the profession around how to effectively and fairly review performance and measurement outcomes, particularly to avoid issues of bias, and to minimise risks of bullying and harassment

- ensuring that outcome measurements are not 'bluntly' used and take into account both differing scopes of practice and experiences

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?

MIGA defers to relevant professional colleges and associations on this issue.

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?

For those outside College contexts, the move towards strengthened CPD may involve significant administrative and time burdens. These have the potential to impede the provision of care to patients and impact on individual practitioners' health and well-being.

It is important for any move to such a system to be a gradual one. This is to ensure the additional time and administrative burdens on practitioners are not unreasonable and are spread out. Time also must be given to them to get used to a new and different system.

Part 2 – At Risk and Poorly Performing Medical Practitioners

Identifying 'at-risk' medical practitioners

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 focused on this group of doctors?

It is reasonable to undertake further research into factors which increase medical practitioners' comparative risk of performing poorly. This would be with a view to determining if any initial assessment is warranted and, if concerns arise, any consequential steps, including remediation where possible.

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

The available evidence on risk factors does not presently support efforts being focused on all of the groups identified as supposedly being at risk of performing poorly. Some of these are starting points for further research, not reliable criteria for assessing potential need for interventions.

However, some of the risk factors identified, including number of prior complaints, quality of underlying qualifications, any unrecognised cognitive impairment, practising in isolation without meaningful interaction with peers and changes in scope of practice without

adequate supervision or support can be relevant factors in determining a practitioner's comparative risk of poor performance.

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

Before identifying who should play a part in proactive risk identification processes, it is necessary to have clear responsibilities, open and regular communication, adequate funding and realistic expectations of various roles.

There are a variety of entities which would play a part in identifying at risk and poorly performing doctors. Already 'local' entities (such as employers, hospitals and other practice entities) play a significant role in proactive risk identification. This also occurs within well-functioning peer groups and via the overriding criterion of mandatory notification. The potential role of colleges within such a process needs to be carefully considered.

MIGA uses data it gathers from notification, complaint and claim processes to determine relevant risk management and education offerings. Where complaints have arisen which raise broader issues than within the complaint itself, there are mechanisms for working with our members to improve practice and reduce their comparative risk of complaints and claims. This occurs through engagement, provision of material, education programs, practice analysis tools, practice reviews, and peer review and support.

Various regulators, particularly the Medical Council of NSW through its performance program, proactively work with practitioners for whom a complaint has identified broader issues, with a view to improving their performance. This occurs through interview, assessment and further education / training.

Assessing: Scaling the Assessment to the Level of Risk

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

MIGA has reservations about certain aspects of the tiered assessment, namely:

- **use of some of the identified risk factors to initiate Tier 1 processes** – for certain proposed risk factors, the sheer numbers involved, particularly gender and age, would subject enormous numbers of medical practitioners to a Tier 1 assessment, presumably on a not irregular basis

- **it is likely that practitioners subject to assessment will feel it to be similar to a disciplinary process**, particularly where it is acknowledged that most of the practitioners in those groups will be able to demonstrate they are performing satisfactorily – this perception would be more so if it is regulators, who also handle disciplinary processes, which are responsible for aspects of the assessment – careful consideration needs to be given to determining how these perceptions can be reduced, or even avoided

- **the validity and effectiveness of the various tiers may depend significantly on who provides them and to whom the results are provided** – there may be broader professional acceptance of the tiers if dealt with by colleges, associations and local entities (such as employers, hospitals or other practice entities), who would not provide information to a regulator until serious issues are identified, such as those meeting the

mandatory reporting threshold, as opposed to earlier involvement of the regulator, ie prior to satisfaction of a mandatory reporting threshold or at an earlier tier of assessment

18. Can you provide feedback on the proposal that multi-source feedback (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?

MSF has potential value, but this would not necessarily be the case in all contexts. It is already used by a couple of colleges, but seemingly more as a CPD tool, not as an assessment of risk of performing poorly.

A better system involves close examination by individual colleges, associations and local contexts (including employers, hospitals and other practice entities) of any deficiencies in existing "*starting point*" assessments to determine practitioners at risk of performing poorly. These may ultimately be better or more cost effective than MSF.

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

These are issues to be determined by bodies who set standards, particularly colleges, associations, regulators and other government bodies, such as the NSW Clinical Excellence Commission or the Australian Commission for Safety and Quality in Health Care.

Poorly Performing Medical Practitioners

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?

This depends on the degree and context of risk of, or actual, poor performance.

From MIGA's perspective, as that of a medical defence organisation and professional indemnity insurer, the role is a mixed one. It already plays an important role through its risk management and education programs, and claims advisory and management functions.

In matters involving risk of, or actual, poor performance short of a mandatory reporting threshold, these are best dealt with by a college, association or other local context (such as an employer, hospital or other health care entity).

The role of a regulator should be limited to setting standards and being involved in matters where the mandatory notification thresholds have been met, or other serious concerns have arisen.

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

There are issues of privacy, litigation risk, potential prejudice and misunderstanding about relevance of data to be overcome before stakeholders can consider sharing data they have about performance of medical practitioners, even on a de-identified basis.

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

The current mandatory reporting threshold has been developed with some care. However, its parameters are still not well understood by the profession more broadly. They are open to debate, particularly around the role of treating practitioners.

There should be further education of the profession around what the notification triggers are, and better use of college or local mechanisms for resolving issues about performance short of mandatory reporting threshold, before reconsidering whether the current threshold should be changed.

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

Normally this would be an issue for the local context, such as employers, hospitals or other health care entities, or colleges and associations.

In certain situations, there may be scope for involvement by medical defence organisations such as MIGA, or accreditation bodies, once issues are identified by colleges, associations or other local contexts (such as an employer, hospital or other health care entity).

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?

It would be worthwhile examining whether a mechanism can be developed to provide strengthened CPD oversight and functions involving the identification and assessment of practitioners at risk of, and performing poorly, who are not associated with specialist colleges or organisations.

The cost involved with this process suggests that it may need to be a governmental body which takes responsibility for it.

Although colleges and local bodies (ie employers, hospitals and other health care providers) may be best placed to lead most remediation functions, they cannot be expected to take on a role for those outside their context.

Further comments – Board's social research

The social research commission by the Board - *Medical practitioners' ongoing fitness and competence to practise report* – provides a useful insight about attitudes in the medical profession and amongst the public which inform consideration of an appropriate approach.

The results should be treated with a certain level of caution, particularly the following:

- **questions asked** – a significant number of the questions asked invite a response to a broad proposition, but in reality there would be a wide range of views on how respondents believe certain things look, or should look, in practice

- **perception and reality** – confidence of the public is imperative, but public perceptions about what is needed, without a clear understanding of what is already in place, must be treated with particular care

- **CPD experiences** – the results relating to CPD undertaken, and what is seen to be useful, by practitioners should be an important part of deliberations over strengthened CPD, particularly as it is based on experience and questioning has been directed to particular forms of CPD

If you have any questions about this submission or would like to explore further, please contact [redacted], Senior Solicitor – Advocacy, Claims & Education on [redacted] or [redacted]

Yours sincerely

Mandy Anderson
CEO & Managing Director

Timothy Bowen
Senior Solicitor – Advocacy, Claims & Education