



Summary of discussions from the Medical Board of Australia's workshop on the Professional Performance Framework

Background

The *Professional Performance Framework* aims to ensure that all registered medical practitioners practise competently and ethically throughout their working lives. It will support doctors to take responsibility for their own performance and encourage the profession collectively to raise professional standards and build a positive, respectful culture in medicine that benefits patients and doctors.

The *Professional Performance Framework* has five pillars:

1. Strengthened continuing professional development (CPD) requirements.
2. Active assurance of safe practice.
3. Strengthened assessment and management of medical practitioners with multiple substantiated complaints.
4. Regularly updated professional standards that support good medical practice.
5. Collaborations to foster a positive culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and wellbeing.

More information about the *Professional Performance Framework* is published on the [Board's website](#).

Summary

More than 115 stakeholders gathered in Melbourne on 15 February 2018 at a workshop to discuss the implementation of the *Professional Performance Framework* (the Framework).

The workshop aimed to establish what needs to be done, and by whom, to implement the Framework in the years ahead. Some of the work involved will be done by the Board, some will be done by other individual agencies and much of it will involve many agencies working together. The workshop included representatives of AHPRA, the specialist colleges, the Australian Medical Council, Australian Medical Association, health complaints commissioners, government representatives and medical indemnity insurers. Health consumer representatives were also invited.

Participants provided feedback on the Framework by completing a SWOT analysis and providing specific ideas about how it can be implemented, in particular when this will require action from multiple stakeholders. They also discussed issues arising from the Framework and how these could

be addressed. The workshop finished with a discussion about the agenda for future joint work and how best to progress implementation.

Medical Board Chair, Dr Joanna Flynn, facilitated the session, stressing that implementing the framework will involve contributions from the profession and extensive consultation. There was broad in principle support for the Framework, with most stakeholders agreeing that it is sensible, consistent, evidence-based, outcome-focused, achievable, pragmatic and balanced to address risks.

There were also many questions about the detail and concerns raised about the pace of implementation, the possible impacts and the challenges inherent in such a major change.

Participants identified a range of important issues requiring more detailed consideration which are summarised below.

Issues discussed

Strengthened CPD

The Board's *Professional Performance Framework* proposes that all medical practitioners participate in 'Strengthened Continuing Professional Development' that will require all doctors to:

- have a CPD home and participate in its CPD program
- do CPD that is relevant to their scope of practice
- base their CPD on a personal professional development plan
- do at least 50 hours of CPD per year, that includes a mix of:
 - reviewing performance
 - measuring outcomes, and
 - educational activities.

There was general support for strengthened CPD and feedback that most colleges have shaped or are shaping their programs to meet the requirements of the Framework.

There was also general agreement that a standardised approach to CPD for all doctors that is flexible enough to accommodate differences in medical practitioners' scope of practice, will allow medical practitioners to tailor their CPD to their learning needs, while also providing assurance to the community that doctors' CPD is designed to improve their practice. It will be important to strike a balance between flexibility and rigid rules in new CPD arrangements.

Participants provided feedback that there are opportunities for specialist and craft groups to define CPD requirements. They can also provide guidance and support to practitioners who will be developing individual professional development plans (PDPs) so that CPD is relevant, likely to benefit medical practitioners' practice and be tailored to their stage of professional life.

Participants acknowledged that promoting reflective practice and peer interaction is positive. However, there are some difficulties that will need to be addressed, including:

- measuring outcomes can be difficult for some medical practitioners, particularly those who do not perform procedures. Data may not be collected routinely to support them to measure their outcomes. Further guidance that may be specialty-specific, will need to be developed to assist practitioners to measure their outcomes.

- concerns about the inappropriate use of documented reflections outside of personal CPD purposes. There was feedback that it will be important to be clear about confidentiality of material produced for CPD.

Opportunities were identified to integrate aspects of strengthened CPD into the workplace, by recognising performance review and outcomes data that are already in place.

Some stakeholders suggested that strengthened CPD may cost medical practitioners more. There was also some concern raised that the changes in CPD, coupled with additional requirements of older doctors (to actively assure safe practice), may lead older doctors to retire, removing a valuable resource from some communities.

CPD homes

The Board has proposed that all medical practitioners will have a 'CPD home' and will participate in its CPD program. The CPD that is undertaken will be relevant to the practitioner's scope of practice and based on a personal development plan.

It is anticipated that in addition to the specialist colleges, there may be other organisations interested in becoming CPD homes. Non-college CPD homes may cater for a range of medical practitioners, such as career medical officers and other non-specialists.

The proposal for CPD homes is still in its early stages of development and workshop participants had many questions. The issues raised will inform ongoing considerations about CPD homes and include:

- The importance of defining the roles and responsibilities of CPD homes. Discussion at the workshop confirmed that there was a range of expectations about what the CPD homes would and would not do.
- The role of CPD homes and the extent to which they will approve and monitor compliance with individual professional development plans, noting there are likely to be a large number of medical practitioners in each CPD home.
- Defining the governance arrangements for CPD homes.
- Developing approval processes for recognising CPD homes, which will require the development of standards and processes, monitoring and quality assurance.
- There are opportunities for cooperation, collaboration, reciprocal arrangements and sharing resources between CPD homes.
- How to deal with practitioners with more than one specialty – will they need more than one CPD home and how will the CPD homes relate to each other?
- Portability between CPD homes.
- Development of contingency plans for non-specialist doctors if non-specialist CPD homes are not approved.

Participants discussed the importance of keeping the CPD home principle as simple as possible, to continue to be focused on patient safety and to reduce unnecessary bureaucracy. They also discussed the risk of adding to medical practitioners' compliance burden and increasing costs.

In relation to approval of CPD homes, it was suggested that the Australian Medical Council could be involved in approving CPD homes, using some of the existing standards now used to accredit specialist colleges.

It was agreed that further work will need to be done to develop the work on CPD homes, taking into consideration the feedback from the workshop.

Doctors aged over 70

The Board has proposed that doctors who remain in practice and provide clinical care will have peer review and health checks at the age of 70 and three yearly thereafter. The outcome of health checks and peer reviews will not be reported to the Board unless a serious risk to patients is identified.

While this was identified as the most controversial element of the *Professional Performance Framework*, there was also recognition that the evidence base for the proposal was strong and increasing.

Stakeholders considered that peer review and health checks would allow older medical practitioners to continue to practise with appropriate assurances about their safety, but recognised there was a workforce risk if older doctors decided to retire rather than be involved in the assurance process. It was noted that rural and remote areas particularly rely on older doctors and therefore their retirement from practice could have significant adverse consequences in these areas.

Some stakeholders expressed concern about the costs involved in health assessments and peer reviews that would be borne by the individual doctor being assessed.

There was agreement that it was necessary for the Board's response to older doctors to be respectful, proportionate, fair and supportive. There was also feedback that the proposal is more likely to be successful if it is doctor-owned and driven, supportive and not punitive.

Workshop discussion included the need for:

- peer reviews and health assessments to be consistent and evidence-based, while flexible enough to cater for differences in scopes of practice
- the roles and responsibilities of the various groups (colleges, peer assessors, health assessors etc) involved to be clear
- criteria for managing adverse assessment results and defining thresholds for further action
- peer reviews to be incorporated into routine CPD processes
- defining a 'peer' and ensuring supports are provided for doctors
- principles guiding peer review, potentially including that:
 - they are independent
 - results are confidential and owned by the medical practitioner being assessed (except when it is necessary to report to the Board)
 - processes are transparent
 - they are free of bias or conflicts. The medical practitioner should have the right to veto an assessor if they identify a potential bias or conflict
 - they are collegial and not punitive, with outcomes leading to remediation when possible, with notification to the regulator only when there is a serious risk to patient safety, and
 - they are integrated into the workplace whenever possible
- principles guiding health assessments should also be developed, potentially aligned to the suggestions above, but separate from the workplace.

Further modelling needs to be done to better understand the number of medical practitioners involved. Stakeholders recognised that many colleges already offer peer review as part of CPD and the same or similar principles that already exist could be applied or adopted.

Professionally isolated medical practitioners

The Expert Advisory Group identified that professionally isolated practitioners are at risk of poor performance. The Board's *Professional Performance Framework* proposes that work be done to:

- develop guidance to help medical practitioners identify the hallmarks of professional isolation and manage the risk, and
- require professionally isolated doctors to do more CPD that involves peer review.

Workshop participants agreed that tools to help doctors identify whether they are at risk of professional isolation would be useful. There is a challenge in raising awareness of professional isolation and the risk it poses, and encouraging medical practitioners to develop insight that this is a potential safety issue. Over time, a wider cultural shift towards greater peer interaction is anticipated, which will be supported by CPD that involves peer review.

Professional isolation is not the same as geographic isolation. Many doctors working in rural and remote settings have well established networks that protect them from professional isolation.

Participants agreed that evidence-based information should be developed and disseminated widely about the risks of professional isolation. Specialist colleges have a role to play in this by contributing to developing resources that will include templates and tools to help medical practitioners identify whether they are at risk of professional isolation. Colleges may also contribute to the development of resources to assist practitioners who are at risk of professional isolation, including as part of CPD offerings.

It was agreed that this work will require input from a range of other stakeholders including regional training providers, professional indemnity insurers and medical schools.

Participants discussed the role of relationships and technology as we tackle the issue of professional isolation. For example, there are existing social media platforms that can be used to raise awareness and provide real time information and advice to medical practitioners. The use of practice accreditation processes and the wider rolling out of Vanderbilt type processes can be parts of a suite of measures to raise awareness and support practitioners who are at risk of professional isolation.

Outcome measurement and access to data

Strengthening CPD requires medical practitioners to complete 25% of their CPD on outcome measurement activities. This will require access to existing data about individual medical practitioner's outcomes to be provided in a way that is meaningful and useful, with appropriate benchmarking.

Participants identified that there is a great deal of data that is collected routinely and there are international examples of doctors being able to access this.

Developing ways to enable access to data, while also ensuring that the privacy of individuals is respected, is a challenge. Privacy is often cited as a reason for not providing access to data, but there may be ways to overcome this.

There was discussion that measuring outcomes is difficult for some practitioners and work will need to be done to develop appropriate outcome measures that will support patient safety. For example, it is more difficult for non-proceduralists and medical practitioners who are not in direct clinical care to access data on their outcomes.

Further work with stakeholders who hold large data will need to be done to explore how those data can be used, with appropriate protections, to support medical practitioners' safe practice.

Cultural change

Establishing 'collaborations to foster a positive culture of medicine' is one of the pillars of the Board's *Professional Performance Framework*. This includes:

- Promoting a culture of medicine that is focused on patient safety.
- Working in partnership with the profession to reshape the culture of medicine and build a culture of respect.
- Encouraging doctors to:
 - commit to reflective practice and lifelong learning
 - take care of their own health and wellbeing, and
 - support their colleagues.
- Urging governments and other holders of large data to make it accessible to individual medical practitioners to support practice improvements.

Stakeholders recognised that cultural change is difficult to achieve but necessary to support safe patient care. The work done recently by the Royal Australasian College of Surgeons 'Operating with respect' campaign demonstrates that while resource intensive, cultural shift is possible.

The work on culture will need to focus on quality and safety, and the link between a culture of respect and patient safety.

Work needs to be done to encourage collaborations that will involve many stakeholders including jurisdictions, hospitals, employers and colleges. Memoranda of understanding may encourage and formalise some of these collaborations.

Participants discussed the importance of leadership and embedding professionalism in curricula at all levels of medical education.

Cultural shift will require engagement, trust and commitment. Increased collaboration across stakeholders, inter-agency information sharing, trust building, alignment of effort and roles were identified as critical next steps.

Remediation

Remediation was identified as an important issue that requires further development. While remediation is covered in the accreditation standards for specialist colleges, there was feedback that some colleges may not have the processes or resources to provide tailored remediation.

Further work is necessary to define responsibilities for remediation.

Practitioner, stakeholder and community engagement

Participants identified medical practitioner, stakeholder and community engagement as essential during the further development and implementation of the Framework.

The Board was encouraged to work with stakeholders as it develops the components of the Framework and to provide clear information about the roles and responsibilities of stakeholders, timeframes for implementation, including transition arrangements. There was also support for the Board to adopt a change management strategy that will enable a carefully phased implementation. Feedback was provided about the time frames necessary for colleges to make the necessary changes to their CPD programs and introduce new systems to support the requirements of the Framework.

There was consensus that a common lexicon is needed to ensure that there is an agreed understanding of terms and requirements.

There was also feedback that the Board should communicate with stakeholders, including medical practitioners, using multiple channels and in multiple ways to help practitioners to understand the proposed changes and the impacts for them.

Next steps

The Board will prepare a work-plan for the development of the components of the *Professional Performance Framework*. While much of the work required will be coordinated by the Board with support from AHPRA, significant input and collaborations with stakeholders will be involved.

The Board reassured stakeholders that the Framework will be implemented over years. It understands that stakeholders need adequate lead times for a smooth and safe implementation and to make transitional arrangements.

The work that will need to be done includes:

- Further development of CPD requirements, including CPD homes, that will lead to:
 - a revised CPD registration standard
 - a review of accreditation standards for specialist colleges, and
 - the development of standards for CPD homes.
- Guidance for medical practitioners on how they can measure their outcomes.
- Resources to be developed about how to identify professional isolation and how to support practitioners who may be at risk of this.
- The Board commissioning advice on appropriate health checks for doctors aged 70 and over.
- Developing a framework for peer review for doctors aged 70 and over, using existing peer review processes.
- Encouraging holders of large data to consider how to give individual medical practitioners access to it.

The Board is now starting the collaborative process involved in progressing this work. This includes developing more detail about the elements of the Framework and setting up working groups for specific actions. The Board expects to bring the workshop group together again later in 2018.

17 April 2018