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SUBMISSION

Options for Revalidation in Australia

7 November 2016

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college of more than 900 Fellows, Associate Fellows and trainees in public and private health settings across Australasia. The College sets standards and provides professional development and specialist qualifications in medical management and leadership to registered medical practitioners.

RACMA welcomes this opportunity to respond to the consultation on the discussion paper for *Options for Revalidation in Australia*.

RACMA's responses to the submission follows the questions in the discussion document, with responses provided for a group of questions. RACMA agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

Overall Comments

A. What will this mean to the majority of medical practitioners?

Questions:

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 the individual 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?

RACMA's Response:

RACMA is supportive of an approach that strengthens CPD and also takes a risk based approach to identifying at risk and poorly performing medical practitioners. RACMA believes it is a reasonable way to achieving the stated dual aims of revalidation – specifically, to maintain and enhance performance, and to reduce the risk of harm to the public in healthcare

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While supportive of the principles, RACMA wishes to highlight a number of points related to the implementation of the suggested approach, and specific application of this approach to RACMA Fellows. Specifically:

- *The CPD program needs to align to diverse roles that often have a broader system wide impact*:- RACMA's specialist medical practitioners are employed in particularly diverse roles, and the scope of practice may differ across the specialty. Specialist medical administrators often work at a level where their work and decisions affect the broader system and hence a whole community rather than an individual patient. The outcome of their work and decisions may be influenced by factors that are beyond the control of the individual specialist medical administrator. As a result, a 'one size fits all' approach cannot be taken, particularly as it relates to the strengthening the CPD model within revalidation. This will impact the way performance and outcomes are measured for specialist medical administrators. It doesn't necessarily mean that performance and outcomes cannot be measured for medical administrators, however, they may need to be measured in ways different from those used for procedural clinical specialists. Further, it may not be as easy to benchmark as is the case with some other specialist roles. Having said that, RACMA can draw on work that has been done in New Zealand to design performance and outcome measurements to align with roles undertaken by specialist medical administrators.
- *Medical practitioners who are not affiliated with the College and working within the scope of medical administration*:- The College raises this as a potential issue to achieving the objectives of revalidation in Australia, as there may be medical practitioners working within the scope of practice of medical administration who are not recently credentialed nor meeting the professional CPD standards of the medical administration specialty. There are many instances of medical practitioners who are not affiliated with RACMA but who work in roles, such as Director of Medical Services. In some cases, these medical practitioners may be working full time in such roles, but in other instances, their medical administration responsibilities may be part-time alongside their main role as a clinician. These practitioners may be compliant with the clinical CPD requirements of the relevant College, but may not have any formal medical administration training or ongoing CPD.
- *A 'single point of truth' for ensuring medical practitioners are fit to practise*:- It will be important that any system moves towards a single platform for collecting and reporting the status of medical practitioners. Employers need to access a 'single point of truth' for ensuring practitioners are fit to practise medicine and to be assured that they are maintaining their practice as it relates to their scope of practice. Currently, the information that can provide employers with this assurance is held in many different places, and significant effort is required on behalf of employers to stay abreast of changes in status of medical practitioners in their employment.
- *Time to implement*:- While RACMA is implementing a CPD program that is largely aligned with that stated in the proposed approach, there needs to be a transition period for implementation for both strengthening CPD, and for initiatives related to identifying and remediating at risk and poorly performing medical practitioners. This transition period, needs to include the development of tools and frameworks, their testing and piloting, and communication of changes to the general RACMA community. RACMA would be happy to be involved in activities designed to assess fitness to practise for RACMA Fellows and members, and members of other Colleges, and to progress these initiatives, including a pilot program.

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B. Guiding Principles – Overall

Questions:

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?

RACMA's Response:

RACMA supports these guiding principles.

Part One: Strengthened Continuing Professional Development

A. Strengthened CPD

Questions:

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?

RACMA's Response:

RACMA supports strengthening CPD so it incorporates practice processes that more effectively demonstrates the practitioner's performance and patient outcomes. However, it is important to note, that specialist medical administrators often work at a level where their work and decisions affect the broader system and hence a whole community rather than an individual patient. Therefore, specialist medical administrators will need to be assessed on outcomes other than an outcome for a specific patient.

The role of setting any Standard, and monitoring CPD compliance should be with the College, but not so that the College is seen to be a direct agent of the regulatory authority (i.e., The College would meet the standards set by the AMC).

It should be noted that it will be important that Standard 9 of the AMC's Standards for Assessment and Accreditation of the Specialist Medical Programs[1] aligns with the model of CPD that will be adopted by the MBA.

[1] "Standard 9 – Continuing professional development, further training and remediation". Source: *The Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015*, AMC, 2015 (effective 1 January 2016), pp 26-28

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B. Guiding principles for CPD

Questions:

9. Is each of these principles relevant and appropriate?
10. Are there other guiding principles for CPD that should be added?

RACMA's Response:

RACMA supports these guiding principles for CPD.

C. Three core types of CPD

Questions:

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?

RACMA's Response:

RACMA supports an approach that contains these different elements for CPD, and it should be noted that RACMA is currently in the process of implementing a model of CPD that incorporates performance review, and where applicable, the measurement of outcomes.

However, RACMA suggests that a 'one size fits all' approach cannot be taken with CPD. Specifically, RACMA's specialist medical practitioners can be employed in diverse roles, and the scope of practice for a practising medical administrator may differ across the specialty. This means a flexible approach needs to be taken in the design and execution of the CPD program so it is relevant to the medical practitioner. The CPD will need to be contextualised to be appropriate to their area of practice.

Further, specialist medical administrators often work at a level where their work and decisions affects the broader system and hence a community, rather than directly impact an individual patient. Therefore, further consideration needs to be given to the appropriate measurement of outcomes, particularly where the outcome may be influenced by factors that are beyond the control of the specialist medical administrator.

The College is seeking guidance from ISO models for quality improvement, and is in the process of developing tools and guidelines for supporting performance review and audit of specialist medical administrators. RACMA can also draw on work that has been done in New Zealand to design

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performance and outcome measurements to align with roles undertaken by specialist medical administrators.

RACMA is concerned about medical administrators working in roles encompassing fields of practice within the specialist role of medical administration, such as Director of Medical Services, however, are not affiliated to the College. RACMA believes there are risks to the safe and effective delivery of healthcare, as these medical practitioners are outside the College's training and review systems.

Part Two: At Risk and Poorly Performing Medical Practitioners

A. Identifying 'at-risk' medical practitioners

Questions:

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?
15. Do you have any feedback on these risk factors identified in the evidence? Do you know of other 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?

RACMA's Response:

RACMA supports this approach as a means of identifying, and remediating at-risk medical practitioners. We see this as quite discrete from issues pertaining to CPD.

RACMA advocates the process of identifying 'at risk' medical practitioners may be more efficiently and effectively performed by a single organisation, and the process is executed according to agreed criteria and process. While RACMA sees it will be the role of the regulator, or an agent of the regulator to identify practitioners that are poorly performing or at risk, the Colleges will need to be part of the process for contextualising risks for a given specialty. To be most effective, the Colleges need to be informed of those that may potentially be 'at risk' so that they can take an active and informed approach to remediation. As an example, Colleges need information about complaints referred from a State or Territory's health ombudsman to AHPRA. This gives the College the opportunity to engage with their member and act on the complaint utilising further criteria developed by the College and the MBA so that ultimately the member's poor performance has been remediated. Early notification allows the College to be informed in terms of individual CPD programs, policy development and future remediation.

RACMA believes the following risk factors could also be considered to identify medical practitioners at risk of performing poorly:

- Male over 65 years
- Solo practitioners
- Practitioners working in remote locations

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- Locum work > 25% of their professional time
- Fly in, fly out work greater than 25% of their time
- Non-attendance at College meetings, such as ASMs
- Trained overseas
- More than two AHPRA notifications in a 24 month period (regardless of resolution).

Some of these risk factors (such as male over 65 years, solo practitioner, trained overseas, and a history of receiving complaints[2]) are currently supported by evidence. RACMA believes the other characteristics warrant research at the national level.

B. Assessing: Scaling the assessment of the level of risk

Questions:

17. What do you think about the proposed options for a tiered assessment?
18. Can you provide feedback on the proposal that MSF[3] 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?

RACMA's Response:

RACMA supports the options for tiered assessment, and this work should be further developed.

The College supports the use of MSF for CPD as it supports learning and reflection. However, the College does not believe MSF is a useful screening tool for identifying at risk medical practitioners, as it is likely to provide results that cannot be reliably benchmarked, and using it as screening (rather than CPD) tool is likely to change the way tool and the results are used by medical practitioners.

There are opportunities to further develop and test aspects of assessment, for example the use of indicators and the use of tools. RACMA is open to discussions with MBA in terms of where the College can be of assistance.

C. Poorly performing medical practitioners

Questions:

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

[2] Please note the work by David Darton and Thomas Jones on "Using data for risk based regulation" which analysed UK data, and further identified the combination of factors that identified doctors at risk of poor performance (Source: IAMRA Conference 2016).

[3] MSF = Multisource Feedback

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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 medical colleges or organisations with robust clinical governance structures?

RACMA's Response:

Employers, regulatory agencies, ombudsmen of various kinds and professional colleges all have a role in identifying, assessing and supporting remediation for poorly performing medical practitioners, or those at risk of poor performance They all have different levels of responsibility to act on the results of that assessment to address medical practitioners' performance but often do so without any knowledge of the others' activities

A reality of working in administrative and legislative silos are common barriers for stakeholders to share information about the performance of medical practitioners. For example, due to barriers, such as privacy considerations and procedural fairness, there is often a lack of awareness in one silo that a problem has occurred in another area. Balancing the rights of individuals to privacy, non-discrimination and procedural fairness with the need to more quickly share information about practitioner performance may be important in protecting the public. These barriers could be ameliorated with the introduction of MOUs between various parties taking into account protections for privacy, non-discrimination and the need for procedural fairness.

RACMA is supportive of the threshold for reporting poorly performing medical practitioners to the Medical Board. However, these issues need to be resolved consistently and expediently. The MBA data in relation to mandatory reporting rates suggests that there is a significant difference and inconsistency in reporting, which may reflect some state-based cultural reluctance to report (e.g., Victoria has low rates compared to NSW and Queensland), and in some instances the time taken to resolve a complaint issue, some of which may be very complex, may further delay consideration of a practitioner's performance.

The individual Colleges should be responsible for supporting remediation of identified under performers that do not meet the threshold for referral to the Medical Board. Where a doctor is not a member of a College (many thousands), a suitable organisation should be charged with the undertaking. A College may decide that it could be a suitable organisation and could volunteer to undertake this for a fee on the MBA's behalf. Given most of these 'non-aligned doctors' work in general practice, RACGP would be the obvious choice.

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