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# AMA Submission to the Medical Board of Australia – Revalidation in Australia

*Overview*

The Australian Medical Association welcomes this opportunity to make a submission to the Medical Board of Australia (the Board) on the *Options for revalidation in Australia* interim report (the Report).

The Australian Medical Association (AMA) does not oppose the concept of revalidation in principle provided that the benefits outweigh the costs of implementation for the proposals. The health budget is limited and any proposal to move resources from health care services to meet regulatory requirements should be carefully considered. In the end, health care costs initially borne by the profession in terms of higher registration fees and higher costs of compliance will be passed onto consumers.

The Board has argued that the main objective of revalidation is to ensure public safety in healthcare. The AMA argues that the key evaluation criteria should be improved clinical decision making and patient reported outcomes.

The AMA's key concern is to clearly identify the public safety problem (or problems) that the proposed revalidation system is intended to fix, particularly given that only a small proportion of doctors are the subject of complaints from patients or colleagues. Clearly articulating and quantifying the problem would allow the medical community to examine, comment and identify potential solutions.

To understand these concerns, practitioners seek data around the characteristics of people making the complaints. Are there groups of patients who have unworkable expectations that require a different communication strategy from practitioners, i.e. is there an expectation management problem in some circumstances? Information about the complainants, particularly if there are trends, would be beneficial. This information is currently not available publicly.

Finally, the AMA notes that it would be pre-emptive to introduce a system in Australia prior to the GMC's independent review of Revalidation which will assess the operation of their system in the United Kingdom. It is imprudent to implement a

system when there is a significant review of another system occurring that could provide vital information as to the effectiveness of any regulatory interventions.

Overall, the AMA strongly believes that further research is needed to provide robust evidence of the problem that should be addressed and the nature of the proposed solution. This should be brought back to the medical community for further comment.

*The role of revalidation*

Like many overseas jurisdictions, the Board appears to be grappling with the question of the role of revalidation. Is revalidation designed to catch those practitioners whose practice is beginning to decline; falling between acceptable and non-acceptable standards or a formative process to support ongoing learning and improvement?

The Report proposes to address both options, and therefore argues that the problems with the status quo are:

- Current Continuing Professional Development (CPD) requirements are not sufficient to maintain or enhance the performance of all doctors; and
- Doctors who are at risk of poor performance are not identified at an appropriate point in time and offered support or remediation.

The Expert Advisory Group (EAG) has proposed guiding principles to assess all recommendations:

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

Whilst these principles and the overall aim of revalidation are admirable they assume the introduction of a revalidation system, and the value of a system is yet to be established.

The AMA advocates that a revalidation system will form part of the management tools that form part of overall system managing the provision of health care in Australia. Improvements to medical practice should be led by the profession, and:

- be cost effective for both the regulator and the participants;
- allocate resources effectively;
- prioritise interventions to manage risk;
- build confidence in the system; and
- be externally accountable.

*Problem 1: Current CPD requirements are not sufficient to maintain or enhance the performance of all doctors.*

The EAG's proposal to strengthen CPD requirements provides a broad theoretical overview of the benefits from adapting the Klass model. The EAG acknowledges that this is a theoretical argument and proposes investigating relationships between CPD activities and their impact on doctor's performance and patients' health outcomes[1]. Like all medical practice, it would ideal if this theory could be tested in some manner prior to full implementation.

Self-assessment of knowledge is essential to the practice of medicine and self-directed life-long learning. It is needed to assess specific learning needs and to choose educational activities to meet these needs[2]. A number of Colleges have developed, or are in the process of developing, CPD programs founded upon evidence based research. These programs have been strengthened to enhance clinical decision making.

The profession is already demonstrating significant leadership in this area and this profession led improvement should be encouraged to continue. The AMA advocates that allowing the Colleges to design and implement CPD requirements with a focus on peer review and partnership for performance development, rather than top down prescribed approaches will be the most effective method to improve practice. In this regard, the AMA welcomes the proposal to develop the new CPD requirements in a collaborative manner with the profession and the medical community.

The EAG's Report does not establish the deficiencies with the current CPD system. Nor does it specify what the desired standard would look like. In order to understand the quantum of the proposed change, it is important to articulate the difference between the current CPD requirements and the proposed standard. These differences will need to be quantified for each of the broad registration groups. For some cohorts this will be a small or insignificant change, for others the changes will be greater.

The AMA requests evidence regarding:

a) The scope of change required;
b) The full cost of transition to the improved CPD standards for practitioners; and
c) The expected improvements in practitioner performance outcomes from these changes;

to determine if a net benefit will arise.

*Problem 2: Doctors who are at risk of poor performance are not identified at an appropriate point in time.*

In Australia, the vast majority of doctors are providing high quality clinical care and have little if any interaction with AHPRA or the Board. There is a small percentage of doctors who will occasionally underperform and an even smaller proportion of

[1] Medical Board of Australia. (2016). *Options for Revalidation in Australia*.
[2] DLA Phillips Fox: *Issues paper – performance appraisal and support for senior medical practitioners in Victorian public hospitals*,
file:///C:/Users/jkotz/Downloads/dla_phillips_fox_issues_paper%20(2).pdf
[15 September 2016]

doctors who are no longer fit to practice. The medical profession practices within a highly regulated environment. This environment provides a multi-faceted approach of continuously assessing an individual's fitness to practice, providing safe systems for them to work in, and responding when harm has been caused or where an individual's conduct has become sub-standard. The processes of annual renewal of medical practitioner registration, professional indemnity insurance, and re-accreditation of health care facilities, ensure that there is constant, ongoing validation within the existing regulatory environment.

Management strategies need to combine top down and bottom up approaches, with bottom up approaches evaluating the two distinct risks. When implementing strategies to manage behaviour, it is important to accurately identify the behaviour and the people you wish to manage. The problem of identifying poorly performing practitioners was accurately described by Hawkes writing in the UK context, "the conundrum is how to identify these doctors without subjecting the rest to time consuming and needless procedures"[3]. The EAG Report list broad criteria for identifying those practitioners who are likely to be at risk of poor performance as being: from 35 years of age; male in gender; number of previous complaints; and time since last complaint.

The EAG appears to propose that these risk factors, and others yet to be developed, are used to identify cohorts or groups of practitioners who are at risk of poor performance. The Report does not specify exactly how these risk factors will be used to identify the cohorts. The application of the factors will determine the size of the group undergoing further assessment.

To illustrate, the low risk cohort to be assessed by Multi-sourced Feedback (MSF) and subject to further assessment, could be:

- If aged over 35 – around 66,000 people[4].
- If aged over 35 and male – around 43,000 people[5].
- If aged over 35, male, subject to a previous complaint – around 2,000 people[6].

There is a considerable difference between the three cohorts and the larger the cohort the more practitioners will be subjected to assessment for potentially little gain as the vast majority of practitioners may be performing well. Stratification of the cohorts with different variables may reduce or increase the cohort subjected to assessment. It should also be noted that it is a fine balance between identifying cohorts and ensuring that the resultant assessment is not viewed as stigmatizing or punitive[7].

The AMA would like more information on:

- Who decides who will be identified for assessment?

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[3] Hawkes N. (2012). Revalidation seems to add little to the current appraisal process. BMJ; e7375, 345.
[4] Australian Institute of Health and Welfare. (2015). *Australian Health Workforce*. Canberra: Commonwealth of Australia
[5] Australian Institute of Health and Welfare. (2015). *Australian Health Workforce*. Canberra: Commonwealth of Australia
[6] Calculated as the proportion of practitioners involved in a notification in 2014/15 by AHPRA multiplied by the proportion who were male using AIHW workforce data.
[7] Lucian L. Leape, M., & and John A. Fromson, M. (2006). Problem Doctors: Is There a System-Level Solution? *Annals of Internal Medicine*, 144(2), 107-115.

- Whether a single or multiple factor/s will be used, if so which one/s?
- What combination of factors will be used to match the level of risk to the proposed tiered level of assessment?
- Whether the risk factors will be weighted?
- How will this strategy be evaluated?

If the suite of variables used to profile risky practice does not include a variable to adjust the results for the complexity inherent in managing riskier populations (e.g. public psychiatry) a selection bias may occur where some practitioners may be unfairly targeted for review. Constant review may eventually discourage practitioners from servicing at risk groups for fear of being selected for review.

In summary, the AMA does not support the current proposal to identify and actively manage doctors at-risk of poor performance as it is described. This proposal requires a considerable amount of further work. The costs of implementation are unknown and at this stage, unknowable. They are considered to be potentially significant[8]. There is no evidence to justify the additional regulation.

Finally, there are particular cohorts of practitioners that because of the nature of their practice may be impacted upon to greater extents than others. When considering a revalidation model, the impacts up these groups should be analysed to mitigate against unintended consequences.

*General practitioners in solo or small practices*

Around 25 per cent of general practitioners (GPs) practice in a solo or small practice (between 1-4 people)[9]. Under the risk factors proposed by the EAG, these characteristics mean that they are more likely to being identified as an 'at risk' medical practitioner.

With regard to identifying doctors at risk, conducting the proposed assessments (MSF) may prove difficult for some practitioners. The vast majority of GPs work at the one location (around 75 per cent), thus their business model does not expose them to a variety of other medical practitioners. Therefore, locating the requisite number of peers, colleagues and co-workers who can accurately discuss their practice for a MSF assessment might be difficult.

There is the potential for greater impacts from the proposed changes for CPD for GPs particularly those not linked to a hospital or other accredited health facility, depending upon the final CPD requirements. The third core type of CPD "Measuring outcomes" is undefined and if a requirement to conduct an annual MSF was introduced, it would be a significant additional burden put upon this group.

GP locums are an important part of the medical workforce, providing relief to solo / remote GPs when they need time away from the business. The nature of locum work

[8] https://www.australiandoctor.com.au/opinions/linda-calabresi/i-fear-revalidation-will-be-a-waste-of-time
http://www.adf.com.au/publication-304-revalidation-doctors-call-for-cost-benefit-analysis-

[9] Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Pan Y, Charles J, Pollack AJ, Wong C, Gordon J. General practice activity in Australia 2015–16. General practice series no. 40. Sydney: Sydney University Press, 2016, Table 4.1

means that these practitioners find it difficult to collect performance data to conduct clinical audits. Alternative systems will need to be found for these practitioners.

Alternatively, for individual practitioners who are not credentialed through another means, the AMA suggests using the data sources held by government to encourage quality practice and help prevent harm. Practitioners have raised their interest in accessing comparative metrics on variance in volumes and outcomes versus peers, to inform clinical practice decisions with the Government as a part of the MBS Review. Comparative data can be effectively used in self-reflection and regular review practices.

The AMA argues that these potential changes pose a significant additional burden on this group, and the likely impacts need to be analysed prior to implementation.

*Rural Practitioners*

Rural Australians often struggle to access health services that urban Australians would see as a basic right. These inequalities mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities. Death rates in regional, rural, and remote areas are higher than in major cities, and the rates increase in line with degrees of remoteness.

It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care.

Rural doctors often carry a high burden for the delivery of health care in rural and remote Australia, and work long hours. The hours worked on average by rural medical practitioners is higher than for those in major cities. For example, when surveyed in 2012, GPs in major cities worked 38 hours per week on average, those in inner regional areas work 41 hours compared with 46 hours in remote/very remote areas[10]. This leads to a lack of time for professional development and family responsibilities. If the resulting requirements from revalidation add to this burden, this will negatively impact upon a rural doctor's ability to care for patients.

Procedural practice is for many GPs one of the highlights of rural practice. It means variety and provides a stimulating and challenging work environment. However, in many areas the utilisation of procedural skills is becoming increasingly difficult. This problem is in large part driven by the closure or downgrading of rural hospitals.

Unless procedural GPs can be assured of a suitable caseload, deskilling becomes a significant problem. In addition, it becomes more difficult to keep up with the latest techniques. Governments must develop a more rigorous decision making framework to govern hospital closures along with innovative programs to allow rural practitioners to keep up with the latest procedural techniques.

The lack of access to a high speed broadband network will make obtaining CPD via online methods considerably more difficult for rural practitioners. There is also a lack of regional training networks which needs to be addressed to enable easy access to CPD activities that review performance. Rural doctors who are not credentialed through a health service organisation will need a system that supports learning similar

[10] The National Rural Health Alliance Inc. (2016). *The Little Book of Rural Health Numbers.* http://ruralhealth.org.au/book/little-book-rural-health-numbers [14 September 2016]

to that in a public hospital. Any change to CPD requirements should not discriminate against rural practitioners.

Rural practitioners are more likely to be over 35, practicing in isolation from peers, and of male gender[11]. These characteristics may lead them to being identified as an 'at risk' medical practitioner under the current criteria. The potential use of MSF is particularly concerning for practitioners who operate a small practice in a very small town. It may be difficult for the practitioner to find a sufficient number of peers to comment on their practice, it may also be difficult for peers to remain anonymous in these circumstances.

There is concern that conducting assessments using MSF will create a stigma for these practitioners, immediately questioning their practice by virtue of the social structures that operate within their location. The AMA is concerned that the patients won't understand that this is a process and will presume that the practitioner is underperforming. These problems can be exacerbated in a close knit community.

*Doctors in Training*

Doctors in Training have a particular interest in revalidation as they often fall outside the usual mechanisms for CPD. Doctors in training work in both private and public hospitals where considerable structured training and supervision occurs. In addition to the training requirements, vocational trainees need to satisfy the appropriate college that they are competent and fit to practice.

The AMA notes that the EAG focussed its strengthened CPD on other groups of practitioners, and argues that the following groups should remain outside of the revalidation system to prevent the duplication of what are already fairly onerous supervision and assessment mechanisms for doctors in training.

***Interns*** – This group holds limited registration. They must complete term assessments with employers as per existing accreditation guidelines from the AMC and are under direct daily supervision by registrars and consultants. This group meets current CPD standards by participating in mandatory education programs provided by employers as a condition of employer accreditation.

***Pre-vocational trainees*** – These are resident medical officers who hold general registration and are not yet part of a training college, but intend to become a vocational trainee in the near future. They are also under direct supervision by registrars and consultants. This group meets current CPD standards by participating in education programs provided by employers. They have often spent large amounts of resources on education and training courses and qualifications for competitive entry into training programs.

***Vocational trainees*** – These are registrars who hold general registration. They are subject to rigorous ongoing assessment from their training college, including direct formal observation, assessment and feedback from consultants. This group meets current CPD requirements by remaining in good standing with their training colleges.

The AMA notes that these three groups of doctors in training are already required to participate in assessment and feedback structures that go well above the standard CPD

[11] http://www.health.gov.au/internet/main/publishing.nsf/content/General+Practice+Statistics-1, Table

requirements for other practitioners. These assessments are tailored to their current career progression and previous performance. As such, they are already participating in a system of revalidation. Further revalidation of this group would only present unnecessary duplication and expense, for no perceivable gain. It is recommended that these three groups of doctors-in-training be exempted from any proposed revalidation program on these grounds.

Non-vocational doctors (i.e. doctors who hold general registration, do not hold a specialist qualification and do not intend on seeking a specialist qualification) do not work within environments with mandated supervision or education and training pathways. They are dissimilar to the above three groups of doctors in training, and as such they should not be exempted from any proposed revalidation system.

**Summary**

The AMA advocates that a revalidation system will form part of the management tools that form part of overall system managing the provision of health care in Australia.

The AMA's key concern with the EAG's Report is that it does not clearly identify the public safety problem (or problems) that the proposed revalidation system is intended to fix. Clearly articulating and quantifying the problem would allow the medical community to examine, comment and identify potential solutions.

The Report does not specify the difference between the current and desired standard of CPD, nor does it detail how the identification and assessment of practitioners for declining performance will operate. The costs of implementation are therefore unknown and, at this stage, unknowable. They are considered to be potentially significant.

The AMA requests that further research be conducted to provide robust evidence of the problem that should be addressed and the nature of the proposed solution. A detailed proposal should be put forward to the medical community for feedback prior to recommending implementation options to the Board.

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