Towards revalidation in Australia: a discussion

Sharing responsibility for the future standards of medical practice

In September 2016, international medical regulators endorsed a new continuing competency framework, designed to help ensure that doctors around the world are competent and keep up to date throughout their working lives.[1] The United Kingdom has introduced a form of revalidation[2] to achieve this, and regulators in different countries have taken a range of approaches to reach the same end.[3] The Medical Board of Australia (MBA) is now examining what will work best in Australia, a system tailored to our health care context; practical, effective and evidence-based.

The MBA has ruled out a UK style revalidation and made it clear that doctors will not be required to resit their fellowship exams every 5 years. The Expert Advisory Group (EAG), which was established by the MBA to provide advice on options for revalidation in Australia, has recommended a model that combines strengthened continuing professional development (CPD) and the proactive identification and assessment of at-risk and poorly performing practitioners.[3]

The premise is that evidence-based approaches to CPD drive practice improvement and better patient outcomes.[4,5] In Australia, strengthened CPD would see all practising medical practitioners[6] participating in three core types of CPD: performance review (such as peer review and multisource feedback), patient outcome measurement (such as audit, mortality and morbidity reviews, and reviews of individual and comparative data), and educational activities. When the practitioner is not involved in direct patient care, other relevant indicators to replace patient outcomes measurements would need to be developed. The proposed changes to strengthen CPD would apply to and have to be achievable by all of Australia's more than 100 000 registered medical practitioners, no matter where they live, their type of practice or whether they are inside or outside the structure of a medical college.

Identifying and assessing at risk and poorly performing practitioners is the other fundamental tenet of the proposed approach. International research[7] indicates that about 6% of medical practitioners are performing poorly at any one time. No Australian research has yet reliably identified how many medical practitioners in Australia fall into this category, and there is not yet any agreed means to identify practitioners at risk of poor performance.

The EAG proposed for discussion a set of risk factors to identify potential poor performers. It reported that nationally and internationally, the strongest risk factors associated with an increasing risk profile are practitioners aged from 35 years, increasing into middle and older age, male gender, number of prior complaints, and time since last prior complaint.[3] Additional individual risk factors include primary medical qualification acquired in some countries, specialty, lack of response to feedback, unrecognised cognitive impairment, practising in isolation from peers or outside an organisation's structured clinical governance system, insufficient levels of high quality CPD activities, and change in scope of practice.[3]

The EAG proposal argues that further work is needed to better understand these risk factors, but that having identified practitioners at higher risk of poor performance, it would be important to ensure that these individuals are assessed in a way that is proportionate to the level of risk they pose.[3] All assessments would need to be non-punitive, tailored, educational and linked to remediation processes designed to return the doctor to safe practice as soon as possible. The EAG also recognised that most doctors in the at-risk group will be able to demonstrate that they are practising appropriately.

The guiding principles shaping the EAG proposal[3] are that strengthened CPD should be more effective, but should not require more time and resources for participants; that all recommended approaches should be integrated with — and draw on — existing systems where possible and avoid duplication of effort; and that all recommended improvements should be relevant to the Australian health care environment, feasible and practical to implement in all Australian practice contexts and proportionate to public risk.

Strengthening CPD is a journey the medical colleges are already on, with many of their CPD programs being evidence based and robust. Research recently commissioned by the MBA[8] asked what the public expects doctors to do to demonstrate ongoing competence, and what medical practitioners believe they need to do to maintain and enhance their knowledge and skills. It found that community trust in doctors is high, that most patients are satisfied with their doctor, and that most patients do not know how doctors are assessed, but believe they should be reviewed regularly. Doctors think reviews should be more focused on known problems. The research found

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that doctors are doing CPD, they believe it is helpful and think that they know what they need to do and how much. The research also showed that while some doctors are doing CPD that is outcome and performance focused, there is a preference for traditional continuing medical education, such as conferences and reading journals, and little appetite for change. It is clear that there are some gaps between what doctors now do and what the community expects.

The problem of identifying doctors who are already performing poorly and those who are at risk of doing so is more contentious. The first question is whether we accept the proposition that there are individual medical practitioners who are not working to the expected standard. And if so, how and by whom should they be identified, and who needs to be responsible for bringing them back to safe practice?

At the September 2016 conference of international medical regulators,[9] there were serious questions asked about whether regulators around the world were doing all they could to keep patients safe. Presentations made to the conference highlighted that regulation has historically responded to complaints about practitioners and focused on those whose practice has already fallen below the expected standard. The conference also heard that, internationally, regulators are now exploring how to use data and their power to look at prevention and early intervention as well as cure.[10]

In relation to doctors at risk and those who are already performing poorly, I believe that there is more to be done to protect patients. There are legitimate questions about who should be responsible for what in identifying and managing these practitioners, and about how to best manage the overlap between problems with health systems and concerns about performance of individual practitioners.

The opportunity now is for the medical profession to take responsibility, individually and collectively, for the future standards of medical practice in Australia. The board is seeking to work with the profession and the community to ensure that the high levels of trust and confidence that the Australian public has in doctors is based on an appropriate framework for ensuring the continuing competency of all those in practice.

The EAG will make its final report to the board in mid-2017. The board will then set a direction and propose what is needed so that doctors in Australia remain competent throughout their working lives. Patients trust their doctors. The profession as a whole, and the MBA as the regulator, are responsible for ensuring this trust is well founded.

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References are available online at www.mja.com.au.

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