

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



**Medical Board of Australia
Consultation on Revalidation**

RACS Submission

November 2016

INTRODUCTION

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training and standards of practice in Australia and New Zealand. Our Fellows and staff work closely with other health organisations to promote the best health outcomes for patients and the community.

RACS welcomes the MBA's transparent and collaborative approach to reviewing the evidence for revalidation in Australia and affirms the following principles:

1. The responsibility for self-regulation and defining standards of professional practice resides with specialist medical colleges
2. Practitioners should participate in a wide range of activities that are multi-modal, interprofessional and which relate to their scope of practice
3. Patients should be given the opportunity to provide feedback on their experience and have access to accurate information to make an informed choice about their healthcare
4. Peer reviewed morbidity and mortality meetings and mortality audits across the health sector should assist in the early identification of individual and/or system failure problems impacting patient care in the individual's local practice context.
5. Greater collaboration between stakeholders will help to support early identification and remediation of underperforming practitioners
6. The on-going availability of a 'self-directed' program that does not have oversight from the relevant professional body undermines the work of the specialist medical colleges in applying standards
7. There is a need for formal oversight of practitioners who are not members of specialist medical colleges

Proposed Approach

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 suggest remediation of individual medical practitioners back to safe practice?

RACS is broadly supportive of the direction being taken by the MBA and agrees that the focus of the proposed approach is both appropriate and relevant. It is about supporting those who practise well throughout their careers and identifying those medical practitioners whose practice has deficiencies. RACS affirms the importance and need for a system-wide approach to improving oversight and remediation of underperforming medical practitioners. RACS is willing to accept responsibility for our professional group and has established and robust systems in place. A revalidation model needs to address how stakeholders can work together to ensure that practitioners who need support, remediation or adjusted scope of practice can be identified reliably and consistently.

Addressing underperformance and influencing cultural change will require a 'rethink' of existing models of collaboration between all stakeholders. RACS is already working proactively to improve surgical culture through its implementation of the RACS Building Respect, Improving Patient Safety Action Plan¹. We have been encouraged by the support we have received, believing this reflects the broader medical profession's commitment to act upon behaviours that have the potential to adversely affect patient outcomes. We also have a responsibility to improve the wellbeing of the health workforce, such that our trainees and others can learn and work in a safe environment. We are seeking more direct collaboration from other stakeholders in the health system, as these issues are not confined to surgeons and surgical practice.

Are there other approaches that could feasibly achieve these aims?

At this time RACS does not offer an alternative to that outlined in the discussion paper. RACS believes that the principles outlined by the MBA will better support practitioners to maintain their

¹ Royal Australasian College of Surgeons, *Building Respect, Improving Patient Safety – RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery*, v. 4, November 2015, http://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf

competency than the exam-based recertification model used in the United States of America, whilst affording a relevant and more workable program than that being implemented in the United Kingdom.

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

Barriers to introducing revalidation in Australia include:

- The perception that revalidation has failed elsewhere (i.e. UK)
- The belief amongst some that it is providing a solution to a problem that does not exist
- That it will be administratively onerous and consume too much of the clinician's time away from providing patient care
- That it will be expensive with concern about who will absorb this cost – the consumer, the practitioner, the hospital, the government or all of the above
- Performance reviews in institutions are typically superficial whilst espousing the multisource feedback (MSF) concept, leading to scepticism about same

The MBA can address some of these concerns through continuing open and transparent consultation on revalidation with its medical practitioners as well as the community. Ensuring that the focus around revalidation is on reducing risk and improving patient care will counter concerns of those who perceive revalidation as an unnecessary interference from government. RACS firmly believes that the onus is on the specialist medical colleges to assume the responsibility of self-regulation and recommends that the MBA make use of the substantial work already undertaken by specialist medical colleges who administer existing Continuing Professional Development (CPD) programs. This would be consistent with the principles of reducing duplication and working smarter not harder.

Guiding Principles

Do you agree with the guiding principles? Are there other guiding principles that should be added? Are there guiding principles that are not relevant?

RACS supports the principles of working smarter not harder, utilising existing systems to reduce duplication and ensuring that the approach is relevant, practical and proportionate. RACS considers that the emphasis of revalidation should not be on those who are already performing well and doing effective CPD through their specialist medical college, but on those who are largely unengaged with existing programs or who have been identified as being at risk of poor performance. Revalidation should be about the doctor and their scope of practice. In choosing the tools to be used for revalidation consideration should be taken of their utility, including validity, reliability and cost.

Strengthened CPD

How can evidence-based strengthened CPD be achieved?

An evidence-based approach to strengthening CPD should incorporate a variety of activities that address the nine surgical competencies and which are centred on improving patient care. These include maintenance of clinical knowledge and skills, assessment of patient outcomes and assessment of performance. To ensure feedback is used in a meaningful and constructive manner, improvement through education or change in practice should be evidence based and subject to evaluation. Bringing together clinicians and medical leaders will be important in ensuring the right balance is achieved to develop a robust and sufficiently agile approach that can adapt to an evolving evidence base.

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

RACS would identify the following stakeholders as being important to involve in discussions about strengthening CPD:

- Specialist Medical Colleges
- Employers and Hospitals
- Medical Defence Organisations (MDO)
- Health Ombudsman

- Departments of Health
- Community/Patient representation

RACS would encourage the MBA to continue its consultation to gain a clearer understanding of what each stakeholder can contribute to the revalidation discussion.

Are there any unintended consequences of this approach?

Delivering a CPD model that is underpinned by interactive and blended learning, on-going peer review and patient feedback, and regular practice review (i.e. reflective practice) will need to be carefully considered in terms of cost. While RACS commends the MBA in prioritising the utilisation of existing systems to minimise duplication, it will be important that these existing systems are appropriately funded and resourced. Australia's unique geography also poses a challenge in terms of delivering a cost effective model of blended and interactive learning opportunities for practitioners. In particular, support is needed for rural and regional practitioners to attend relevant educational activities and have access to performance review activities and ongoing clinical coverage for their communities while they are absent. Consideration also needs to be given to supporting practitioners who provide their services, often pro bono, to deliver education activities, perform practice visits or who undertake a peer review of clinical practice. To encourage meaningful self-reflection that supports improved patient care, it is important that practitioners feel able to be honest and open in their feedback without fear of repercussion.

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

The success of revalidation in Australia will heavily rely on collaboration between all stakeholders and it will be important for the MBA to clearly articulate their expectations of the role of employers and other agencies. The evidence presented in the EAG report clearly demonstrates the correlation between repeated complaints against a practitioner and an increased risk to patient safety. The fragmented approach between stakeholders compounds efforts to offer appropriate support and supervision of practitioners with a history of complaints, impeding the system's ability to reduce risk and improve patient safety. RACS has recently assumed a leadership role in addressing complaints against surgeons about discrimination, bullying and sexual harassment (DBSH) by working with public and private hospital operators to establish memoranda of understanding (MoU) to facilitate a timely response to these issues as they arise. RACS would encourage the EAG to engage with stakeholders to gain a better understanding of their capacity and willingness to work in partnership.

Guiding Principles for CPD

Is each of these principles relevant and appropriate?

RACS supports the guiding principles for high quality CPD programs as outlined in the discussion paper as being relevant and appropriate.

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

A balanced CPD program incorporates activities that address all nine technical and non-technical competencies. RACS cannot identify any other specific guiding principles for CPD at this time.

Three core types of CPD

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

RACS supports the MBA's inclusion of performance review, outcome measurement and validated education activities. The approach is consistent with the RACS CPD program which emphasises:

- Participation in activities that are related to the surgeon's scope of practice
- Promotes peer engagement and performance review
- Encourages participation in multi-modal and interprofessional learning environments
- Provides support to those who are experiencing difficulty and/or who require remediation

The MBA will need to ensure that the balance and weighting of activities is appropriate, with some of the more valuable education opportunities requiring a period of reflection and consolidation of

learning before they should be undertaken again. For example, RACS recommends that surgeons undertake a multisource feedback review no more than once every 3 years, as this allows for reflection on the feedback, identification and implementation of changes and evaluation of any improvement or on-going gaps in their practice. In this respect careful consideration needs to be given to the framework being relevant and proportionate, with an emphasis on ensuring a focused, coordinated and proactive response to those practitioners who are at risk or are underperforming.

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?

RACS believes it has the appropriate processes and policies in place to support a transition to revalidation. The RACS CPD program² has had a requirement for mandatory peer reviewed surgical audit since its inception and the College has been at the forefront of delivering a mortality audit framework that is now available in most public and private hospitals throughout Australia. The national audit system is complemented by peer reviewed audit participation within the surgeon's clinical community. RACS seeks to improve morbidity and mortality meetings by promulgating standards, particularly around improvement in practice. RACS is currently piloting a MSF assessment underpinned by the RACS surgical competencies and it is anticipated that this will be made available to the broader Fellowship in the near future.

To support quality assurance of educational activities for CPD purposes, RACS provides an approval process that requires education providers to submit their activities for review against a defined standard (i.e. learning objectives, evaluation etc.) and approves approximately 300 events per annum. The RACS CPD Program is structured to ensure participants engage in a variety of learning modalities and from 2017 will include a requirement to participate in a reflective practice activity each year.

Before a full assessment of the implications of revalidation for specialist medical colleges could be undertaken, further detail is needed about the proposed model of delivery, particularly as it relates to:

- The requirements for reporting by medical authorities to the regulator/s and related two-way exchange of information
- Further information about expectations regarding compliance – noting that most specialist medical colleges operate under a self-reporting model with an annual audit/verification requirement
- Availability of funding and resources associated with revalidation, particularly as it relates to underperformance and “at risk” practitioners which requires an extensive commitment in terms of time, support and coordination

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?

RACS remains concerned that there are a number of inconsistencies in the MBA standards that allow some medical practitioners to evade appropriate oversight. The inclusion of a ‘self-directed’ program within the standard³ weakens the influence of specialist medical colleges in enforcing compliance and identifying issues with a practitioner that may pose a risk to the community.

The Australian health system covers an expansive and at times isolated population. Many medical practitioners without an association with a specialist medical college work outside major centres in rural or regional centres, at times without adequate collegial support or oversight. The impact of limited oversight of practitioners in some centres has resulted in devastating consequences for these communities, often with a focus on the individual rather than adequate analysis of system failures. If revalidation is to achieve its objective of proactively identifying doctors at risk, greater oversight and system improvements are needed.

² Royal Australasian College of Surgeons, *Continuing Professional Development Program*, January 2013, http://www.surgeons.org/media/18810259/continuing_professional_development_cpd_guide_2013.pdf

³ Medical Board of Australia, *Mandatory Registration Standards*, October 2016, <http://www.medicalboard.gov.au/Registration-Standards.aspx>

To address these issues, RACS would strongly encourage the MBA to remove the option of undertaking a 'self-directed' program and to investigate the role specialist medical colleges could take in providing oversight to non-members. For example, the RACS CPD program is available to non-member surgeons with approximately 200 Australian and New Zealand surgeons using this to record their CPD participation. RACS would welcome more discussion on this issue. To gain better insight into this area, it may also be useful to canvass the views of practitioners who are not subscribed to a College CPD program.

Identifying 'at-risk' medical practitioners

Is it a reasonable approach to work to better understand the factors that increase medical practitioner's risk of performing poorly so that efforts can be focussed on this group of doctors?

Identifying practitioners that pose a risk to themselves, their patients and the health sector more broadly is an important, challenging and necessary component of revalidation. For example, there is now irrefutable evidence that demonstrates that cognitive and technical skills decline with age, at a time when they may be under less scrutiny by clinical governance processes or undertaking locum work across a number of hospitals. The correlation between repeat complaints/notifications is also becoming clearer, with a preliminary analysis of data indicating that 4% of surgeons were subject to 3 or more notifications to AHPRA over a 4 year period and accounted for more than a third (36%) of all notifications about surgeons⁴.

Existing processes for managing concerns about practitioners are fragmented and would benefit from greater coordination between relevant stakeholders. At present the lack of data sharing limits our knowledge of risk and our response to those who are not performing to the required level. Data sharing needs to occur at all levels and across jurisdictions. This includes those setting the standards, the medical colleges enforcing the standards, regulators and those receiving the complaints. The local system with its ability to observe outcomes has a key role here through their local clinical governance structures, processes and bodies.

While CPD programs are limited in their ability to identify poor performance, they can help to highlight a practitioner who may be in need of support. Each year RACS randomly verifies 7% of participants in the CPD program and re-audits Fellows who have failed to comply with their requirement by the due date in the previous year. Any surgeon can also be referred for verification at the discretion of the Chair of the Professional Development and Standards Board. Targeting at risk medical practitioners for audit of their CPD is an effective and cost efficient way to determine at a high level whether they are disengaged with on-going contemporaneous education or peer engagement. RACS also believes that it would be appropriate that those surgeons who have been identified as performing poorly or at high risk be subjected to regular clinical review (oversight) and verification of CPD activities.

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

The risk factors identified by the evidence outlined in the discussion paper are broad and not unexpected. While offering a snapshot of risk based on existing available data, a collaborative model which includes a broader set of data specific to the Australian setting would help to better elucidate risk factors.

Specialist medical colleges, hospitals and medical defence organisations hold a substantial amount of data, some of which supports the view that there is a clear trajectory of risk associated with complaints and the likelihood of future complaints. Less is known about those complaints that do not reach a threshold for investigation. At this stage there is a lack of coordination between agencies and also concerns about privacy and data sharing which limits the ability to effectively predict and monitor at risk practitioners. RACS is working to address this gap through establishing MoU's with a number of hospitals to better manage complaints about its Fellows in relation to accusations of discrimination, bullying and sexual harassment. RACS would encourage more

⁴ Personal communication, Marie Bismark and Nigel Broughton

discussion about how the various agencies can come together to better support the early identification of underperforming practitioners beyond that already negotiated around DBSH.

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

Anyone who works or interacts with the health system can play a part in the identification of at risk or poorly performing doctors with key stakeholders including:

- Specialist Medical Colleges
- Employers and Hospitals
- Accreditation Agencies (i.e. ACHS)
- Medical Defence Organisations (MDO)
- Community/Patient representation

To support early identification, those speaking out must feel confident about being able to raise a concern without fear of any repercussions. This needs to be balanced with the practitioner's right to a fair and unbiased investigation and hearing.

Assessing: scaling the assessment to the level of risk

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

RACS supports a tiered approach to scaling the assessment that is proportionate to the level of risk and adopts a similar approach when assessing breaches of the RACS Code of Conduct under its Sanctions Policy⁵.

Can you provide feedback on the proposal that 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?

RACS supports regular MSF - especially when managed in the local context of practice - as offering a valuable opportunity for reflection that can assist in identifying underperformance. While an effective tool, MSF is not necessarily a low cost option when taking into consideration:

- The cost and time associated with administering the survey
- The time associated with a rater undertaking a review of their peer/s - rater fatigue may occur where individual healthcare workers are asked to rate multiple practitioners on multiple occasions
- The time and expense of having a facilitator available to deliver and interpret the results
- The cost and time to monitor the improvement in practice relative to the risks identified in the assessment

There are also a number of other factors that may limit the effectiveness of a MSF assessment, particularly eliciting honest feedback from those who are under supervision or assessment by the practitioner undertaking the review.

While broadly supportive of MSF as an assessment tool, RACS would welcome further discussion about its use within a revalidation framework. This may include consideration of options for indemnification for those providing input to an agreed MSF process or standard.

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

There are a number of generic MSF tools available and it would be advantageous to look at existing processes to establish Australian benchmarks. When developing the MSF assessment for RACS Fellows, the College has used the Surgical Competence and Performance Guide as a

⁵ Royal Australasian College of Surgeons, *Sanctions Policy*, November 2015, http://www.surgeons.org/media/22263224/2015-11-27_pol_fes-pst-054_sanctions.pdf

baseline measure⁶. While this does not aid comparative data analysis against other medical practitioners or overseas surgeons, it does allow for a consistent measure of a surgeon's performance against the competencies as assessed from training until the end of their surgical career.

Poorly performing medical practitioners

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

Ensuring collaboration between all agencies will require extensive cooperation, including clear and measurable expectations. As outlined in the response to question 16, with the exception of patients and accreditation bodies, the following stakeholders who have a role in identifying poorly performing or at risk practitioners can also support remediation:

- Specialist Medical Colleges
- Employers and Hospitals
- Medical Defence Organisations (MDO)
- Health Ombudsman
- Departments of Health

To support the identification of poorly performing practitioners, further consideration should be given to the different aspects of underperformance. Specialty society audits and safety registries with outlier management processes can support the review of clinical performance that is relevant to a practitioner's scope of practice. Complaints that relate to concerns about professional behaviour may not necessarily be easily identified through clinical performance or poor outcomes. Further consideration should be given to developing a set of 'screening tools' to identify technical and non-technical risk factors that help to understand poor performance.

What is each stakeholder's responsibility to act on the results of that assessment to address medical practitioners' performance?

The responsibility to act on results of an assessment needs to be clearly articulated by the MBA after extensive consultation with relevant stakeholders. A shared understanding of expectations and responsibilities will assist to ensure a timely response, minimise duplication of effort and reduce the risk of a poorly performing practitioner 'falling between the gaps'.

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

The complexity of Australia's healthcare system contributes to a number of barriers to sharing information about performance. A lack of understanding about privacy obligations or concerns about legal liability may contribute to a resistance to share information. RACS is trying to overcome these barriers in its response to addressing discrimination, bullying and sexual harassment. As outlined in response to question 8 and 15, RACS has established MoU's with a variety of institutions that support cooperation and information sharing. The MoU is an important first step in establishing on-going dialogue to address at risk and poorly performing practitioners in regards to discrimination, bullying and sexual harassment. Clinical performance will overlap with this dialogue.

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

The threshold for reporting poorly performing medical practitioners to the Medical Board is a challenging area with little guidance or evidence on what is appropriate (or inappropriate). While guidance at a mandatory level is clearer, there are behaviours and issues that do not constitute mandatory reporting but which bring to attention that a practitioner may be at risk or that patient safety is being affected. In an active hospital, institutional or practice environment, a local response may be productive. Informal or formal responses may be required and observation, morbidity and

⁶ Royal Australasian College of Surgeons, *Surgical Competence and Performance Guide – A Guide to the Assessment and Performance of Surgeons*, June 2011, http://www.surgeons.org/media/18955288/surgical_competence_and_performance_guide_2011_.pdf

mortality meetings and leadership/governance may bring matters to notice and be part of the response. Health issues may be detected which are contributory and should be managed as such.

RACS manages breaches of the College's Code of Conduct internally through its Sanctions policy. Serious breaches have been directly reported via the Australian Health Practitioner Regulation Agency (AHPRA). Active dialogue with MBA is sought after such notifications. Procedural fairness to the surgeon is paramount, so efficient MBA review is important all round. RACS has also been addressing failure to comply with the CPD standard, which has included the termination of some Fellowships. While this has been reported to AHPRA, these surgeons continue to have FRACS listed on the public registry. RACS remains concerned that this is misleading to the public and limits their ability to make an informed decision about their healthcare. Even in instances where a Fellowship has been terminated for failure to maintain membership, we believe it is important that these matters are reported to the regulator. Removal of Fellowship indicates that a medical practitioner is no longer participating in activities such as CPD within the specialist medical college framework.

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

RACS believes that specialist medical colleges have an important role to play in remediating under-performers in conjunction with their employer. Remediation is most often required for departure from acceptable practice in non-technical skills and behaviours. RACS has established a mechanism for clinical standards reviews which provides a valuable means of maintaining standards for both individuals and surgical units. Such reviews may identify activities and outcomes that are below acceptable levels, and can recommend to the surgeon and/or institution where corrective measures are appropriate. Remediation may have positive outcomes for the surgeon but certainly should maintain quality and safety for the patient.

In the last 18 months RACS has focused on remediation activities that address discrimination, bullying and sexual harassment, including the launch of a RACS Surgeons Support Program and increased peer support for IMGs through the Clinical Director (IMG) and for Fellows through an Executive Director for Surgical Affairs (EDSA) in Australia and New Zealand. RACS recognises that surgeons appreciate being able to confidentially discuss matters with a practising surgeon who has experienced similar types of crisis. The EDSAs are also available to provide advice to hospitals should they identify surgeons who would benefit from additional training.

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?

All specialist medical colleges invest a substantial amount of resources into their CPD programs, managing compliance and remediating poorly performing Fellows. Since 2014 RACS has achieved 100% compliance for those Fellows participating in the College program, an achievement that has required an investment in further resources and a focus on increased communication, monitoring and support to Fellows who are experiencing professional and/or personal difficulties.

It is becoming increasingly important that all stakeholders work towards a consistent model which provides reassurance to the community that all practitioners are held to the same standard regardless of their Fellowship (or membership) with a specialist medical college. RACS believes that this is an area that warrants further discussion.

References

Royal Australasian College of Surgeons, *Building Respect, Improving Patient Safety – RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery*, v. 4, November 2015, http://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf

Royal Australasian College of Surgeons, *Continuing Professional Development Program*, January 2013, http://www.surgeons.org/media/18810259/continuing_professional_development_cpd_guide_2013.pdf

Medical Board of Australia, *Mandatory Registration Standards*, October 2016, <http://www.medicalboard.gov.au/Registration-Standards.aspx>

Royal Australasian College of Surgeons, *Sanctions Policy*, November 2015,
http://www.surgeons.org/media/22263224/2015-11-27_pol_fes-pst-054_sanctions.pdf

Royal Australasian College of Surgeons, *Surgical Competence and Performance Guide – A Guide to the Assessment and Performance of Surgeons*, June 2011,
http://www.surgeons.org/media/18955288/surgical_competence_and_performance_guide_2011.pdf

Royal Australasian College of Surgeons, *Code of Conduct*, May 2016,
http://www.surgeons.org/media/346446/2016-04-29_mnl_racs_code_of_conduct.pdf