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Dr Joanne Katsoris
Executive Officer
Medical
Australian Health Practitioner Regulation Agency
GPO Box No 9958
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**By email: medboardconsultation@aphra.gov.au**

Dear Dr Katsoris

**Submission to Expert Advisory Group Interim Report on Revalidation**

Avant welcomes the opportunity to provide input into this consultation.

Our submission is attached.

Please contact me on the details below if you require any further information or clarification of the matters raised.

Yours sincerely

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Head of Advocacy

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## About Avant

Avant Mutual Group Limited ("Avant") is Australia's leading medical defence organisation. It is a mutual organisation, owed by its members, and offers a range of insurance products and expert legal advice and assistance to over 70,000 medical and allied health practitioners and students in Australia. Our insurance products include medical indemnity insurance for individuals and practices, as well as private health insurance, which is offered through our subsidiary The Doctors' Health Fund Pty Limited.

Our members have access to medico-legal assistance via our Medico Legal Advisory Service. We have offices throughout Australia, and provide extensive risk advisory and education services to our members with the aim of reducing medico-legal risk and promoting good medical practice and patient safety.

## Avant Submission

## Expert Advisory Group Interim Report on Revalidation

Avant Mutual Group Limited ("Avant") is Australia's leading medical defence organisation and medical indemnity insurance provider. It is a mutual organisation, owned by its members, and offers a range of insurance products and expert legal advice and assistance to over 70,000 medical and allied health practitioners and students in Australia.

Avant welcomes the opportunity to provide this submission on the Medical Board of Australia's (MBA) revalidation model. This submission is divided into four parts. Part A presents Avant's key points about the proposed revalidation model. Parts B and C address the two components of the proposed revalidation model. Part D sets out the principles which Avant believes should underpin any revalidation model, and makes recommendations for future progress.

### A. Key points

1. The majority of doctors practising in Australia are competent, perform well and provide safe and effective health care.
2. Lifelong learning, the maintenance of high standards of practice and continuous improvement are key aspects of medical professionalism.
3. Avant generally supports the continuous improvement of the performance of the profession as a whole and of proactively identifying and remediating doctors at-risk of poor performance.
4. Avant is not convinced that these aims will be achieved under the proposed model.
5. Opinions on the MBA's current proposal are divided, and there are strongly held views against the proposal.
6. A phrase such as "continuous quality improvement" should be used in place of "revalidation" as it is a better description of the aim of strengthened continuing professional development (CPD) and avoids the negative connotations associated with the word "revalidation".
7. Strengthened CPD should aim for continuous quality improvement across the profession rather than be a process for targeting at-risk doctors.
8. Continuous improvement of the profession, and identifying at-risk doctors, are two separate issues, and should be considered separately.
9. Further research is needed to assist in determining the early identification and management of poor performance before implementing an identification and remediation scheme.
10. Further research and review, including the implementation and evaluation of one or more pilots, is required before rolling out any proposals Australia-wide.

11. We believe that for any model to succeed, it must have the support of the profession and must operate within an open and just culture where practitioners feel supported to raise concerns without fear of being targeted.

## B. Strengthened continuing professional development

Avant supports the guiding principles of CPD as outlined in the interim report, but has a number of concerns about the proposed model:

1. There is a lack of evidence to show that revalidation/strengthened CPD will lead to better patient care and safer medical practice. CPD is used as a proxy for competence without clear evidence that participation in CPD achieves competence or leads to better patient outcomes. In any model, the outcomes of strengthened CPD need to be identified and evaluated.
2. Any CPD system must be easy to implement and not take doctors away from their core business of treating patients. It is not clear how multisource feedback (MSF) would be implemented in the context of private practice or out-of-hospital practice where doctors work in consulting rooms alone with the patient. In these contexts there will be limited opportunities for peers to judge a colleague's competence.
3. There is a lack of clarity around governance. Will governance rest with the Colleges or the MBA or both?
4. There is an emphasis on peer review and practice visits as part of strengthened CPD but no suggestion about training programs for reviewers. To provide meaningful engagement, those undertaking peer review and practice visits must be appropriately trained in assessing against agreed standards and providing effective feedback to doctors.

   It is not clear how strengthened CPD will be funded. Doctors would be concerned if the proposal would lead to an increase in registration fees, which would contribute to pressure on healthcare costs.

### *Responsibility for CPD*

The operation and implementation of CPD programs rests primarily with the Colleges.

We acknowledge the considerable work undertaken to date by many Colleges to enhance their existing CPD programs with a view to improving the performance of their members. We believe that the Colleges should continue to be actively involved in setting the standards and content for quality CPD programs.

CPD programs need to be flexible enough to be applied in different practice settings and scenarios, but there is currently an absence of consistent profession-wide minimum standards/content for all CPD programs.

Avant's experience suggests that the profession would benefit from CPD which extends beyond clinical skills and includes non-technical skills such as areas of risk, quality, safety and professionalism. Non-technical skills could be the subject of a common curriculum across all Colleges and we recommend that the Colleges work collaboratively to enhance their CPD programs in this regard.

### *Relationship between part 1 and part 2 of the model*

The relationship between strengthened CPD and identifying at-risk doctors is not clear. Part two of the proposed model notes that MSF will be the starting point to assess whether doctors are in at-risk groups.

It is not clear precisely how this will work (particularly within an educative framework), who will have the obligation (if any) to report practitioners to the MBA if they "fail" MSF, and what the threshold will be.

If the purpose of strengthened CPD is to identify and target at-risk or poorly performing doctors, we believe that the profession will be reluctant to fully participate in it for fear of being reported.

Strengthened CPD should aim for quality improvement across the profession rather than be a process for targeting at-risk doctors.

## C. Identifying and assessment of at-risk and poorly performing practitioners

Avant generally supports the use of the tiered approach of the Vanderbilt model for dealing with unprofessional and inappropriate behaviour and practice within medicine. The aim of the Vanderbilt model is to provide the ability and opportunity to practitioners to self-correct.

We understand that a number of healthcare provider organisations are currently trialling a Vanderbilt approach to managing poor performance. It would be useful to understand the outcomes of these trials before implementing such an approach across the profession as a means of identifying, assessing and remediating at-risk and poorly performing practitioners.

Avant has the following concerns about the second component of the revalidation proposal:

1. The risk matrix identified in the EAG report is too broad and needs to be refined. Any screening tool for high risk doctors needs to be more precise. We agree that more work needs to be done to better understand the factors that increase the risk of poor

performance. We believe that this should be the subject of dedicated research in the Australian context.

2. The culture of blame that can exist in some healthcare settings is a barrier to identifying at-risk and poorly performing doctors and to effective education and remediation of poor performance. The profession is wary of anything that suggests that they will be identified and blamed. For this approach to have the confidence of the profession, we believe that it needs to operate within an open and just culture where practitioners feel supported to raise concerns.
3. It is not clear how benchmarks and standards of care will be set to permit comparison between peers. In our view the Colleges and specialist societies should take the lead in setting the benchmarks for comparison.
4. The proposed approach focuses on the individual and does not appear to take into account that doctors often work in teams and within systems. Quality and safety and risk management literature recognises that system risk is a key cause of or a contributor to poor performance. We believe that this should be addressed in in any model that is proposed.

## D. General principles and recommendations

One of our key recommendations is that the MBA should not use the word "revalidation", but instead use a phrase such as "Continuous Quality Improvement". In our view, "continuous quality improvement" is a better description of the aim of the strengthened CPD model, and avoids the negative connotations associated with "revalidation".

Continuous quality improvement should be:

- focused on quality improvement and improving the competence and skills of the entire profession
- about improving and enhancing the professional practice of all doctors
- educative and not disciplinary/punitive
- supportive and collegial
- effective in achieving better health outcomes for patients
- standardised across the profession but sufficiently flexible to take into account different scopes of practice within the profession and different specialties in the profession
- evidence-based
- intrinsically valuable
- simple, not over-engineered, and easily implemented within existing healthcare systems
- relevant to the field of practice and context
- procedurally fair, clear and transparent.

Continuous quality improvement would encourage doctors to assess their skills against applicable standards and expectations for quality health care, and assist doctors to identify skills which require development or improvement.

In addition Avant recommends the following:

1. Any risk identification activities should be focused on objective underlying risk factors (rather than broad-based "proxy" variables (such as age and gender). Further research should be undertaken to assist in determining the early identification and management of poorly performing doctors before implementing an identification and remediation scheme.

2. There should be a greater emphasis across healthcare and the profession generally on risk management as a potential solution. Risk management is a mature academic discipline and set of techniques which can be learned and should be applied by any doctor in all speciality groups.

## Avant contact details

**If you have any queries about this submission, please contact:**

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