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MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 16 MARCH 2016 AT 6.15 P.M.

THE TOPIC: FITNESS TO PRACTISE MEDICINE - HAVE WE GOT THE BALANCE RIGHT?

SPEAKERS: DR ALISON REID
MS HELEN TURNBULL

Transcript prepared by Karen Russell

DR MICHAEL DIAMOND: Welcome members of the Medico-Legal Society, your guests and of course our distinguished speakers who are here to present their talks this evening.

The background to tonight's choice of topic comes from one of our discussions in the Committee. It comes up quite regularly, really questioning the value of many of the oversight bodies and bodies to which we are accountable professionally and looking at the value that comes from the programs that are run, particularly in this case, regarding fitness to practise medicine. Those of us here this evening are well aware that in New South Wales this is a highly evolved process. There has been a long history of addressing these issues very carefully and being very cognisant of differentiating fitness to practise aspects in different ways from health, conduct and performance, which I am sure will all be addressed by our speakers.

Our first speaker tonight is Helen Turnbull, with whom I am sure all here tonight would be familiar in one form or another - working in a collegiate way; knowing Helen across the table at various hearings; and those people having had the privilege of wise counsel from Helen have high regard for that. I do have to introduce Helen nevertheless, but will be brief, because she really does not need much introduction.

Helen was admitted into legal practice in New Zealand, England and in New South Wales, before she joined Avant, where she is now special counsel in professional conduct. She specialised in medical law in the UK and advised the largest health authority in Europe. In her role as special counsel at Avant she provides input into their services, and Avant being the largest medical indemnity insurer in Australia, that expertise is spread widely for the benefit of many of the members of Avant. Helen's particular areas of expertise and interest are in professional regulatory law. Helen has a specific interest in the national registration and accreditation scheme in Australia and sits on the New South Wales committee that currently is reviewing the National Law in New South Wales.

Without further introduction, Helen, could you address the Society.

MS HELEN TURNBULL: Thank you very much. The topic tonight is "Fitness to practice medicine - have we got

the balance right?" and I am going to start off with a story, or indeed a number of stories.

I am going back to 1956 when a nurse was working in the surgical ward of a small rural hospital and a young man came up to her and said: "Can you help us?" My wife is sick and no one seems to be listening to us. She is in a lot of pain." The nurse said: "Okay, I will go and speak to the sister." The husband said: "Do you believe us?" The nurse looked at the wife and said: "Yes, I think she is really looking ill." The nurse went and saw the sister who said: "Nurse, the surgeon has been and said there is nothing wrong with this patient. Moreover, he has ordered her bed be transferred to outside the bedpan cleaning area where there is a lot of noise and in that way we might be able to get rid of her and free up the bed for a needy patient". The nurse went off duty and two hours later the patient died as a result of a ruptured ectopic pregnancy. An issue of fitness to practise circa 1956?

Let us move on to 2011. A 33 year old woman attended the emergency department complaining of nausea, dizziness and abdominal pains. She was fully examined by a junior doctor who diagnosed endometritis. He prescribed antibiotics, reassured her and sent her home. He neither ordered a pregnancy test nor called the on-call gynaecology team. A week later the woman collapsed with severe right iliac fossa pain. She was hypotensive and tachycardiac. She was diagnosed as suspected appendicitis. An abdominal ultrasound and routine blood tests were ordered. The ultrasound demonstrated a large amount of fluid in the pelvis and abdomen and an empty uterus. At laparotomy, neither tube could be saved. Another failure to diagnose an ectopic pregnancy.

And now this year, February 2016, a healthy 30 year old pregnant woman experienced episodes of PV bleeding whilst on holiday. She saw a general practitioner who referred her to the emergency department of the local hospital. She was seen there by a registrar, who took blood for testing, swabs for culture and checked her blood pressure. An ultrasound was requested. The blood test suggested that the woman was still pregnant but this was not followed up. Her scan also showed an ectopic pregnancy, but the scan results were incorrectly interpreted and reported. She was told that she had a complete miscarriage and she was sent home. She subsequently collapsed necessitating a laparotomy at which time they managed to save one of the tubes. (Some

of the facts in this case have been changed because of its recency.)

So there we have it - 1956, 2011 and February 2016. As Aristotle noted over 2000 years ago: “While everything changes, everything remains the same ...” What were the issues here? It was a failure to recognise a deteriorating patient, a failure to follow up, failure to escalate, inexperience and sheer incompetence. These cases are examples of those failures.

When I chose the failure to diagnose an ectopic pregnancy as the sentinel event, I was not looking at events that never happen, but instead at cases that often occur. I chose cases of late stage ectopic pregnancies. I accept early signs of diagnosing ectopic pregnancies can be really difficult, but in these three particular cases it should have been diagnosed and it was not.

So “while everything changes, everything remains the same”. 1956, 2011, 2016. What are the elements that we really need to ensure that our doctors are fit to practise? First we must ask the question: “What is fitness to practise?” It can mean a whole range of things that we so glibly talk about. For example it could be: competency; a process to improve healthcare; capacity; values such as integrity and trust; a process to maintain standards; a process to discipline a health practitioner; or just simply responding to public expectations.

Little wonder there is so much confusion as to what it means by fitness to practise. From my perspective we need to have a starting point. There are a range of definitions of fitness to practise and a persuasive definition of fitness to practise for me comes from the UK Health and Care Professions Council. In March 2016 the Council said, “Professionals need skills, knowledge and character to practise their profession safely and effectively. Fitness to practice is not about professional performance only, it also includes acts that may impact on public protection or competence in the profession or just simply the regulatory process. This may include matters not directly related to professional practice.” Cases such as doctors involved in paedophilia would come within this fitness to practise definition.

To sum up when we are looking at a fitness to practise model the starting point is to actually define it.

We have to be careful not to fall into the revalidation traps which have occurred in England. In 2008 revalidation was an idea; in 2012 it was implemented; but now in 2016 it is to be revamped by the General Medical Council (GMC). This is as a result of significant criticism of the revalidation system which is like a re-certification system. In the United Kingdom (UK) it is bureaucratic, expensive, and seen as a waste of time. Certainly the GMC itself recognises that there are real issues with the UK revalidation process.

Yesterday 15 March 2016 in *Pulse,* the Royal College of General Practitioners (RCGP)in the UK announced the need to revamp the revalidation process to help General Practitioners (GPs) slash their administrative workload. The RCGP announcement then went on to issue a new guideline on the revalidation process aiming to reduce the administrative workload. The basic idea was the GP would do 25 units (hours) of Continuing Professional Development (CPD) and then do 25 units reflecting on what was the impact of what was learnt from that CPD. The total hours were therefore 25 plus 25 equalling 50 hours.

The reaction to this guidance of the Royal College of General Practitioners designed to slash the administrative workload of GPs was swift. “Am I being stupid but this appears to me to be 50 hours of CPD with reflection, rather than 25 hours doubled by reflection.” (Anonymous GP Partner *Pulse* 15 March 2016). As the Anonymous GP Partner put it in *Pulse:* “So instead of doing 25 hours and doubling it up, we now have to do 50 hours with all that free time we have!! Idiots couldn’t run a p*** up in a brewery.”

Clearly emotions are running high on the revalidation issue. It is critical that Australia is very careful about the nature of the process it is going to introduce.

The Medical Board has funded research looking at potential fitness to practise models for Australia. Its advisory committee which is reporting at the end of the year is looking at a risk-based regulation. This committee will consider different approaches the reactive or traditional old style process and the proactive or revalidation/re-certification process.

The reactive process looks at complaints, incident data, annual returns and mandatory/self-reporting. From assessing complaints we know older practitioners are more likely to get into trouble as are isolated or solo

practitioners. We also know that if you have a complaint, there is an increased likelihood that you will receive more complaints. This type of information is collected from complaints data. It is part of assessing the risk factors where fitness to practise might be an issue. There is incident data available from the IMS system in New South Wales Health reporting adverse events. There is also information gathered when a doctor renews their registration, such as informing AHPRA of a health issue or an outstanding complaint. Finally there is the highly sensitive area of mandatory reporting and also self-reporting. For example under the National Law it is required that you notify such things as a change of privileges at a hospital or being charged with an imprisonable offence. These notifications need to be made within seven days.

So there is a lot of available data to be collated and looked at. However this is all reactive data and it is that balance between the reactive and the proactive data that is important. Proactive data is CPD, whether it is mandatory or voluntary; audits; appraisals like the continual appraisal system of the revalidation process in the UK, and which Alison Reed is going to talk about and multi-source feedback.

The next issue to consider are the stumbling blocks. These include the over-stretched health profession, limited resources, usable data, speed of technology and competing interests. I am not going to discuss an overstretched health profession or limited resources as they have been ‘done to death’. Useable data on the other hand is an interesting stumbling block. We have many available data sets to utilise including hospital data, the Clinical Excellence Commission data, AHPRA data and insurance data - yet they are all incompatible. What we need is useable and relevant data. What do we know from the data and what of that knowledge is important? Is the doctor performing well in the hospital setting but not in private practice? Do they need more structured supervision or mentoring? I understand that with respect to AHPRA and the insurers, consideration is being given to bringing the data together to achieve some uniformity.

The speed of technologic change has taken us by surprise. Every young doctor has a mobile phone and using it to take photographs in the hospital to send them to their consultant. The Medical Board decided to make rules about this practice, but by the time it did so there was such a “Twitter attack”, the Medical Board immediately

backed off. This is a good example of what is becoming an increasingly real issue in that regulators are too slow and too conservative. We are alright about today, but we are not planning for 20 years hence. To plan properly we need to ask the right questions now.

Finally there are competing interests. The regulators always talk about protection of the public, protection of patients, public interest and safe practice, but the National Law which regulates all registered health professionals, also has an objective about workforce mobility. That objective is the continuous development of a flexible, responsible and sustainable Australian health workforce. In my view, there is a tension between these two objectives. There is a tension between government agendas on workforce and regulatory health bodies. What if pharmacists do clinical assessments, physiotherapists prescribe and podiatrists operate. It may be less about the issue of safety of practice and more about a flexible and responsible health workforce.

There are conflicts between the various health boards. Recently in the news the Chiropractor Board has been criticised for being far too slow in controlling those chiropractors advertising and performing spinal manipulations. Finally, the other health boards have united to convince the Chiropractor Board to take some action. This is an example of conflict and competing interests within the boards.

These days we talk about medicine as a commodity where we expect quality and value for money when we are treated. Just today 16 March 2016 the Australian health regulator has released 61 recommendations of what not to do, that is, waste of time medical practices. On this occasion all the boards and the colleges have come together to produce finally something that is pragmatic that does relate to fitness to practise.

I acted for a general practitioner last week who demonstrated five aspects that are really common in a poorly performing practitioner. He had done more than the prescribed amount of CPD – in fact well beyond it; he did not have his own general practitioner; he was prescribing antibiotics for everything; he provided drugs of addiction on request to demanding patients and had very poor medical records. I see this day in and day out and the doctor always tells me: ”Well look, my patients love me, so I’m safe to practise”. What type of

fitness to practise model would pick up this type of performance at the earliest stage.

Another doctor said, “I’ve never had a formal complaint against me in 43 years of practice. That’s not to say I’m perfect, we all make mistakes. I try my best, but if things go wrong that’s life”. I found this doctor’s comment interesting from the point of view of looking at the balance of a fitness to practise model. What does this comment say about that individual and how would he be tested and appraised? As he has never had a formal complaint there is no reactive component. There might be something in his registration renewal, such as a disclosure of a health issue but unlikely. He is making mistakes, but says he is not perfect and if things go wrong, “that’s life”. This is a doctor in a one doctor town where he is very much needed. The issue is how to identify these practitioners who are potentially at risk and how to deal with them. If our thinking is only about what is current today we are going to be out of date, as noted earlier, with the Medical Board and social media. How can we look at that ordinary practitioner in a way that is beneficial to the community without watering down the standards of clinical practice?

In relation to the scenario described above of a one doctor isolated rural community town, no one complained because they were concerned that they would lose their doctor. It was better to have a bad doctor than no doctor at all. As the doctor said: “All I want is to care for my patients, is that too much to ask?”

Fitness to practise is a difficult topic and the Medical Board of Australia will take their time in assessing what should be done in Australia. They are aware of the pitfalls in the UK and American models. They will take it slowly and presumably will build on the CPD model.

The fact is that the nurse in 1956 was my mother and she remembered that patient and what happened to her as clearly as if it was yesterday. When things go wrong, it not only affects the patient, but also impacts on the practitioner. Fitness to practice is essential, whatever the balance. Thank you.