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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

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QUESTIONS

DR PENNY BROWNE: I was interested in your comment about getting it right with the New Zealand system of revalidation and being reliant on CPD. I am just wondering where the evidence was for that and why their CPD system might have some outcome measurements.

DR ALISON REID: There is not a whole lot of data from New Zealand either. There is a paucity of data everywhere.

I think that there are some things that we can accept as intuitively right even if we do not have data. If a person is engaged in a good CPD program, it is no guarantee that they will perform well, because there may be a whole lot of other factors at play. However if a person is not engaged in any CPD at all, I think it is reasonable to think that at some point they will start to perform poorly, as the knowledge and skills that they developed through their practice erode if they are not keeping up to date.

I think that engagement in CPD is something that is generally accepted as being a reasonable thing and therefore basing a revalidation program around a CPD program would also seem to be a reasonable thing to do. It does not fulfil that often unstated objective, which is finding the doctors whose fitness to practise may have deteriorated which is why I think that sensibly you would do at least two things. You would require everyone to do their CPD in a good accredited program, but you would supplement that with some other markers from the wealth of data that is available, to which we have no access currently, that might give you a bit of a pointer towards the people that are actually struggling in practice. That kind of data can be surgical outcomes, it can be prescribing data, it can be a whole range of things but I think CPD is the first step and in fact it has already been done in Australia. People have to make a declaration about their CPD with their annual renewal now and there is an audit process. A few people get caught up in an audit process to prove their declaration but I think we could take that a little bit further.

What I would be quite opposed to would be going as far as it has gone in places like the UK and Canada where it is an enormously complex and time consuming process with very little evidence of effectiveness.

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MS KIM GARDNER: Solicitor. My question is in relation to, the majority of us here. There are lots of solicitors here, who do work with doctors. What is your advice to those of us working with doctors who think, whilst in the course of working with them in whatever manner or shape or form, "I do not believe you should be practising anymore?

We have all had it go through our minds but because of our professional capacity - like Helen is not going to say to a doctor through her professional role as their advocate, by the way, I think it is time to retire. What is your advice in those situations, because we have all come across them numerous times?

MS HELEN TURNBULL: It is a difficult situation because you have a number of roles – you are acting for the individual doctor, but also you are looking at a way of helping them as well, in a way the doctor may not perceive, it is a journey of developing understanding as to the best outcome for that particular doctor. In particular, where there is a lack of insight you are hoping that on that journey the individual will develop insight along the way.

Often it takes a team approach. I have found that when you are trying to encourage people to come to the right decision, including retirement or taking their name off the register, collegiate support is most helpful. That is someone that they trust who can talk to them. They are not going to trust a lawyer, you can be sure of that. Therefore you organise someone that matches their personality or matches their age. So someone like Malcolm Stuart, who is a medical advisor, I would choose to talk to a doctor who is near retirement age and should start thinking about it.

In answer to your question Kim, it is difficult and often we are assuming a number of roles while caring for the doctor. If we take a team approach to looking after the individual, we can better handle what we encounter. However it is a journey and sometimes we do not get there in the end.

DR ALISON REID: I think that is absolutely right. There are a whole lot of reasons that doctors keep working. I have heard a lot of them over the years. It is often financial. These are often doctors who have not planned for their retirement or who have lost their entire life savings in some Nigerian internet scheme. Sadly, I have

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seen that happen and I think it was probably a manifestation of that doctor's cognitive impairment, that he had been sucked into that scam.

There are often doctors that have second families, young kids still at school and at university and feel a real financial imperative to keep working. It can be because they are entirely defined by being a doctor and have nothing else in their life, they have no outside interests. Maybe they do not want to spend a whole lot of time at home with their spouse or indeed, their spouse does not want them to spend a whole lot of time at home.

There are whole lot of reasons why doctors keep on working and I think that everybody has a role to play here. I was talking about this last week at a combined colleges meeting, where I think early in doctor's training they need to be encouraged to think about it and to plan for their retirement, both financially and socially.

Colleagues need to be prepared to have the difficult conversation. It is a bit like the conversation you might have with your mum about driving the car. It is the same sort of difficult conversation, but people need to be prepared to have that conversation and if the conversation does not produce the required effect, you have the regulator as a backup.

I know that people are reluctant to do that because regulators get a bit of a bad wrap, but I think in this day and age, regulators deal compassionately and fairly with older doctors particularly those who are a bit reluctant to retire. At the end of the day they have the power necessary. If it really comes to it and you cannot do it the easy way, the regulator is the only body that has the power to do it the hard way.

So many doctors rely on their colleagues to tap them on the shoulder. I wish I had a dollar for every time somebody told me that "my colleagues will tap me on the shoulder". But the reality is that they do not and often they are not in a position to know how well their colleagues are practising. They are not sitting in with them with patients. They do not really know and it is a really dangerous way to plan your retirement because probably at that stage you have had a disaster I would suspect.

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GP: Just following on that point, perhaps a statement and a question if I may. It comes down to culture I think. Some say there are three things that you can do to insult doctors, insult my profession. One is to question their integrity, threaten their independence and threaten their income.

All of those things are threatened by revalidation, so we need a culture that does come back to safety, that overriding culture that safety is the paramount thing. What do we do about our peers and colleagues who we know we will not send our family to? What do we do about that, because somebody else's family is seeing them?

That brings us to the question of part of that culture being getting used to perhaps measurements of performance or quality. Overseas I have seen quite a number of metrics introduced with payments, which I am not advocating necessarily here in this country, but doctors are getting used to certain measures and the most valuable measures they are finding are patient reported measures, patient reported experience measures and patient reported outcome measures.

That is going to be used here in Australia. It is already being used in certain aspects in projects from the Ministry of Health in New South Wales. I wonder whether taking those measures and somehow combining them with other data which you do not have access to, which hopefully you could, you could envisage some sort of system where the patient experience is just as important, experience and outcomes, to measure the quality of the work done by individual doctors. Do you ever see that possibly happening?

DR ALISON REID: I think those sorts of measures are certainly very promising. I think they are more useful in some environments than others and even more useful in an environment where the patients do not have so much choice as to where they go such as in a UK kind of environment, where you can only see the doctor whose "book" you are on. I foresee some limitations in the Australian context where if a person does not like the GP, they will go somewhere else. Therefore the measures that you get from those patients will be positive measures because they have already selected the GP that they would like to go.

So I think there are some limitations, but as I said in my talk, without creating a monster, you really need to

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triangulate information from as many sources as possible and it is really a balancing act. It cannot be onerous for the doctor. It should not be onerous for the regulator, but to be meaningful we really need to accumulate information about practice from a whole lot of sources.

MS HELEN TURNBULL: I would only add that one of the significant changes in the fitness to practice approach internationally is the involvement of laypeople sitting on the panels, the influence they have in the decision-making as to what is expected of the particular doctor. I think that is something that we are going to see an increase of. It is not about breaking down self-regulation of doctors, but having that extra input by the public, however it does create a danger. I remember being on one interview where the layperson began advising my doctor on how to diagnose a subarachnoid haemorrhage. We all just sat there shaking our heads because she had taken it out of a text book which was an old one of her grandfather's. Further she was the dominant member on the panel. We were appalled and took action. She now no longer sits on the panel.

DR PAUL FRIEND: Psychiatrist. Given what you said, that we do not know quite how to evaluate what is happening with doctors and we try to identify bad apples. Putting aside pilots, is there any profession in the world, any country, with the diversity of skills that doctors have, that has got this right, how you evaluate what their profession is doing - whether they are lawyers, whether they are architects, whether they are engineers or are we really at the cutting edge - which is what I think we really are at?

MS HELEN TURNBULL: I do not believe there is. I think the plumbers have got it right, they just do what they want and then if they are caught, they will fight it and charge you more.

I think that basically no. From the years that I have been involved, there are always these questions from these countries that are looking at setting up a basic regulatory process like Indonesia or other developing countries and they are asking the same questions. Certainly over the years that I have been involved, there has been no answer and they have looked at the outside disciplines, because it is so complex.

DR ALISON REID: I think the short answer is no.

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DR MICHAEL DIAMOND: I must thank our speakers for the way they have approached the evening. I think the applause says it all. Thank you very much for putting this amount of energy and this amount of common sense and good wisdom into this talk. Thank you.

MEETING CONCLUDED

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