PO Box 745 Indooroopilly QLD 4068 AUSTRALIA Ph 1300 662 173 or +61 7 3378 26
Email info@pacificsolutions.com.au Web www.pacifictranscription.com.au

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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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DR MICHAEL DIAMOND: I would now like to introduce Alison Reid, a medical graduate from the University of Tasmania.

Alison has had a distinguished career as a senior medical administrator and has managed complex and difficult teaching hospital environments, where "prima donnas" and all sorts of "special people" like to run their own race. She has seen her fair share of the problems of fitness to practise. She has worked and is currently working internationally in a number of arenas and for various consulting bodies. From 2000 until 2010 Alison was the Medical Director at the New South Wales Medical Board and then the New South Wales Medical Council. In that role she was instrumental in bringing into practise the performance legislation that was enacted during that period, the impairment programs and also administering the medical aspects of the conduct program.

I am sure Alison will have many interesting and informative things to say about our topic this evening, so Alison, over to you.

DR ALISON REID: Thank you Michael.

This is the third time I have spoken to this group and I think it has been at about five yearly intervals. You should be aware that in five years' time I very much hope to be retired and you will need to invite somebody else.

Fitness to practise is a term that is bandied around in regulatory circles. It means different things to different people at different times but for me, fitness to practise is a framework for all regulatory decision-making. It enables us to ask what is really a simple question: "Is a doctor fit to practise" or alternatively, "what does the doctor need to do to be fit to practise?" It can be applied to every aspect of regulation and we know what these aspects are. It is about registration – the initial decision to register a doctor; about dealing with complaints; about performance matters; about health matters and about serious conduct and disciplinary issues.

If you think about the application of fitness to practise in that initial decision to register a doctor, it is not just a question of whether a doctor has a recognised qualification – that is the easy part. That said, in relation to international medical graduates it can be a bit tricky, because what is a recognised qualification? That is something that is being grappled with at an

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international level by trying to define the medical courses that in fact produce graduates that are fit to practise. However in addition to the qualification question there are many other things that need to be considered in that initial decision to register. It is about the doctor's health, about their professional conduct, for example, whether they have had any criminal convictions and their history with other regulators.

The most obvious application of fitness to practise in regulation is in complaints management. Does a series of complaints or indeed a single complaint, indicate that the doctor has deficient knowledge, deficient skills, suspect professionalism or ethics. Performance assessment has grown out of the fitness to practise model, as has been mentioned and the law now provides for a non-disciplinary program where concerns about a doctor's fitness to practise can be explored with a view to remediating deficiencies and keeping the doctor in practice if it is safe to do so.

However tonight, I want to concentrate on two particular aspects of fitness to practise. The first is about re-validation or maintenance of competence and the second is about the application of fitness to practise principles in disciplinary proceedings. The latter is not an arena in which you tend to hear the language of fitness to practise, that, at the moment seems to be limited to matters of professional performance and health or impairment. I want to propose a way, perhaps, that fitness to practise is relevant in the disciplinary arena as well.

Firstly re-validation, a term that causes most doctors to blanch and go a little bit shaky in the knees. It is a term coined by Sir Cyril Chantler, an ex-president of the General Medical Council in the UK. However I heard recently that Sir Cyril now vehemently regrets coining the term and may also regret a number of iterations of the model that has been tried in the UK.

Re-validation is really meant to demonstrate to a regulator and to the community that doctors continue to be fit to practise throughout their career and that is its simple objective. I believe there is general agreement that doctors cannot rest on their laurels and rely on their initial qualification for the rest of their career. They have to do more than that.

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The current buzz concept is that doctors have to maintain their EPAs. Does anyone know what an EPA is? That don't just indicates we are all generation X or lower. EPAs are Entrustable Professional Activities, and you heard it here first. EPAs are essentially a set of skills that a doctor requires to be a doctor. At the point of the doctor learning an EPA, which may be a procedural skill or a simple skill like taking a patient history, there is a learning curve and there is a point at which that learning curve hits a performance level which is safe and acceptable. Then hopefully, they exceed that level and excel in that aspect of practice.

The reality is that that curve is not necessarily maintained at that acceptable level. It may well start to drop away and decline until it hits that acceptable level on the way down and in fact fall below it. We recognise that this happens for a whole range of reasons. It may be because a doctor is no longer using that skill. For example they might have been an orthopaedic trainee and learnt to do all the general orthopaedic procedures but very early in their career decided that they would "do knees" and become a knee specialist. As a result, their EPAs in many other aspects of orthopaedic practice may well start to decline. Other issues that can cause decline in the quality of practice skills are things like health and cognitive impairment the latter of which is a significant issue for regulators worldwide.

Most doctors do the right thing without being forced to and many doctors resent the imposition of a complicated re-validation program. The sacred discourse about re-validation is that it is about quality improvement for everybody. The profane discourse is that it is about finding bad apples and either requiring them to improve or revoking or amending their registration if they do not. Most regulators will admit, at least privately, that re-validation or their attempts at re-validation are in fact about both. It is about a rising tide that raises all boats. However it is also about finding bad apples.

Many models of re-validation exist throughout the world but as Helen has mentioned, the General Medical Council has really led the way. I sometimes feel it has led us off into the abyss, but none the less it is the General Medical Council's model that has received the most attention. Its model requires a number of components which is reasonable because any attempt to assess performance needs to be looked at it from a variety of perspectives to arrive at a valid answer. So the GMC

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model requires an annual employer-led performance appraisal with a portfolio of experience to be submitted which shows all the CPD activities that the doctor has undertaken, self-evaluation, and a 360 degree evaluation by colleagues and patients. It is enormously time consuming and labour intensive. Further it is immediately apparent that the GMC model is not applicable in places such as Australia where the majority of doctors are not employees. You cannot rely on an employer-led appraisal system when most doctors are not employees, many work in the private sector and many are in solo practise.

The GMC model is under review at the moment by Professor Julian Archer, with whom I have met on a number of occasions recently and whom I have questioned about the terms of reference for that review. It seemed to me that it was much more about process than outcomes. At a conference last year about re-validation he said that very few doctors in the UK were coming to their attention as being problematic considering the number that are covered by the process. So I asked the question whether those doctors that are falling out of the re-validation program, the “bad apples”, are the same bad apples that are known to the Council for other reasons, such as through the complaints process. His response was that would have been a really good question to look at. This confirmed my impression that what they are really looking at is the process rather than the outcomes. As far as I can see, at this time there is no really good evidence that the highly complex and expensive re-validation program is actually achieving what it sets out to achieve; namely to improve everybody’s performance and to identify people who are falling short.

Everyone is struggling to produce evidence for the value of maintenance of competence programs or re-validation. Last year the International Society of Medical Regulatory Authorities held a symposium on re-validation. For me the single most compelling message from that meeting was the fact that after all this time there was still no good evidence of its value and there is a sense of panic in the re-validation community now to try to produce that evidence because people are starting to drift away from their belief in the re-validation system. Two small Canadian provinces have dropped their re-validation programs because of lack of evidence and because of the expense of those programs. The rest of the Canadian provinces remain somewhat evangelical, I have to say.

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For my money, the New Zealand system has considerable merit. It requires doctors to be linked to an accredited college CPD program and if they meet the college requirements then the Medical Council is satisfied. It is as simple as that. Of course the key is that it has to be an accredited program. You have to have confidence that the program that they are involved with is in fact a reasonable program. This leaves only a handful of doctors who are outside the college system and the New Zealand Medical Council has developed some innovative ways of dealing with these doctors and giving them access.

In my view, Australia is in fact in a very good position. We have the benefit of observing re-validation programs elsewhere and the evidence, or the lack of evidence. Nevertheless, there is no doubt that there are political and societal demands for AHPRA to do something about re-validation and I am sure that there will be developments in this regard. However I am confident that the approach will be measured and sensible as we will learn a lot from the experience of other jurisdictions.

People often talk about the aviation industry, and ask why we cannot learn from it. Personally I am bored with aviation, but here I am talking about it. It seems to me that the problem is that medical practise is so diverse and so complex, with so many variables, whereas it is relatively easy to put a pilot in a simulator and simulate for them take-off and landing and the relatively small range of things that might happen in an aircraft. I concede this might be naïve of me. It is almost impossible to do that in a medical practice setting. What are the parameters that you would be testing a person for?

I agree Helen is absolutely right in saying that, as an adjunct to that requirement for CPD, we need to find ways to access the data that is available because I think there are markers of poor performance in that data. Our difficulty is to get access to data. I believe that there are some very compelling prescribing markers, for example. In general practice there are some sets of prescribing data that would give us good information about the quality of practice. Access to this would allow the regulator to have a more targeted approach rather than trying to apply a system to everyone.

At a conference I attended last week, a geriatrician told us that there is a move, certainly in New South Wales, but perhaps Australia-wide, for all hospital inpatients

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over 65 years to have a simple screening test for cognitive impairment. This is because it is now well-documented that patients with cognitive impairment do badly as inpatients. They have much poorer health outcomes, regardless of their reason for presentation, than unimpaired individuals. It occurs to me that perhaps we should do cognitive testing for all doctors over 65 years as well. This may be slightly controversial and that milestone is actually not that far away for me either.

Moving on from re-validation I would like to talk about the application of fitness to practise principles to disciplinary decisions. This is more in the realm of personal reflection. It is really focusing down on that regulatory function of hearings in the Medical Tribunal or Professional Standards Committee in relation to serious matter of professional conduct. I have sat on a number of Medical Tribunals recently and I have been reflecting about how fitness to practise principles or framework could be applied to cases where a doctor is suspended or where their registration is revoked.

We always talk about regulation as being a protective jurisdiction and to a large extent that is true, although I am sure it feels punitive to the doctors that are involved. Most actions arising out of disciplinary hearings are about restrictions and structures that enable a doctor to practise safely and therefore protect the public, and that is definitely about fitness to practise.

However it is sometimes necessary to put a doctor “on the bench” - not the judicial bench but the other one - either because their clinical performance is so bad or because there has been a serious breach of professional standards, such as having sex with patients. In these cases, there is often a long review period so that the doctor’s registration is suspended or revoked and then there is a defined period during which the doctor cannot seek restoration to the register. Long review periods, can be as much as 10 years. They send a very strong message to the public about maintaining the integrity of the profession and there is clearly a deterrent effect there.

But what about the less egregious cases where a tribunal might be thinking about putting a doctor “on the bench” for one year or two years, not five years or 10 years? How does it make that decision about what is an

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appropriate period of time? Section 149C(7) of the Health Practitioner Regulation National Law does not give any assistance in answering that question, so what is the basis for that decision?

There was a very interesting decision in the Court of Appeal in Lee v The Health Care Complaints Commission in 2012. It was an appeal against the length of the non-review period.

In that decision it says:

> "Comparison with the outcome of earlier cases may be useful if those earlier cases show some discernible range or pattern. Such a range or pattern even when discernible cannot be regarded as a precedent indicating what is correct. The range or pattern is, at best, a reflection of the accumulated experience and wisdom of decision-makers. The range or pattern will potentially be of value only if it is possible to gather from it an appreciation of some unifying principle.
>
> Since the predominant consideration is the protection of the public, a decision can only be made by reference to the facts of the particular case and by considering what measures are needed to ensure that the future behaviour of the particular practitioner is shaped in a way that is consistent with that protection."

To me, the last of those points supports the fitness to practise approach, although it does not use "fitness to practise" terminology. I will read it again:

> "A decision can only be made by reference to the facts of the particular case and by considering what measures are needed to ensure that the future behaviour of the particular practitioner is shaped in a way that is consistent with that protection."

Fitness to practise, to me, is a useful decision-making framework in cases where it is anticipated that the doctor can, at some stage, return to practice. Regardless of what it is that they did that brought them to a disciplinary hearing, it is anticipated that they will be able to return to practice at some point. The worst case is a long non-application period. That usually means they will never be able to return to work. Effectively it is a backdoor way of removing them from the register

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permanently, although we are always reluctant to say that they can never come back.

However in those less egregious cases I would suggest that the decision on the length of the suspension or non-application period can be helped by asking the question: "How long will it take this doctor to be fit to practise again?" The answer to the question depends on the nature of the case - is it about their professional conduct, their ethics, their mental health, their clinical knowledge or their skills? What do they need to do to be fit to practise again and how long will it take? How long might it take an unwell doctor to get the treatment they need to return to good health? How much psycho-therapy might a doctor need to understand their professional behaviour and the error of their ways? I think these questions are often implicit in the decision-making process in Medical Tribunals, but in my view, there is benefit in making them explicit.

I recently sat on a sexual misconduct case. The decision has been handed down, and so I can say the name. It was Dr Priyamanna, presided over by Boland J. In her office after we had heard the case, we had exactly this conversation: How long might it take him to be fit to practise again? The Health Care Complaints Commission had sought a review period of three to five years. The practitioner's barrister sought a period of 18 months and as the Tribunal we had to make a decision about where we thought the review period should sit.

In her (our) decision Boland J wrote:

> "Doing the best we can on the evidence before us, we are of the view that a period of two years should elapse before the practitioner may again apply for a reinstatement order. In determining this period we find it is likely that in his present state of uncertainty about his future the practitioner may not be emotionally ready to take on board our findings, address his lack of appropriate clinical skills, including communication with female patients and to seek counselling.
>
> Allowing a period of time for the practitioner to reflect on these matters and then take remedial action, appears to us to require a period of not less than two years."

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If I may be so bold as to paraphrase that decision, we decided that it would take two years for Dr Priyamanna to be fit to practise again. Of course, it will then be up to him to demonstrate that he has done everything necessary when the re-application is heard. To me, this explicit consideration of the doctor's fitness to practise placed the decision squarely in the realm of protective action rather than punitive action and I felt comfortable that there was sound basis other than just precedent for that decision.

So the title of our talk tonight is *Fitness to Practise - have we got the balance right*? I do not know what the answer is either. I think it is probably yes and no. I think Australia's registration processes and health programs and performance assessment programs are clearly based on fitness to practise principles and I think the balance is right in those areas. Re-validation is probably a different matter. Until there is real evidence that it does in fact make all doctors more fit to practise and identifies doctors that are not fit to practise, we need to be really cautious about heading into a complex or expensive, and certainly divisive, process.

As for our disciplinary processes, I think we could make more use of fitness to practise principles to explicitly support our decisions rather than relying on historical precedent. Fitness to practise is not just about the soft options of health and performance. I think it is equally applicable in disciplinary action. In my view, it would make our disciplinary decisions more understandable, less arbitrary and certainly seem less punitive than they must currently seem to some practitioners.

I will leave it there. Thank you.

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