“Safe Doctors – Fair System” Project

Consultation and Framework Discussion Paper

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In addition to the members of the Senior Stakeholder Reference Group, the following people assisted greatly in their contribution as members of the "Safe Doctors – Fair System" Steering Committee and as Sponsors of the project.

Steering Committee

The following are members of the Steering Committee:

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Sponsors

The Sponsors of the "Safe Doctors – Fair System" project are:

- **Prof Stephen Duckett** PhD DSc FCHSE FASSA
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Introduction

Over recent years, there has been a growing recognition that "system failures" are responsible for the significant majority of preventable patient harm. Appropriately the focus has shifted away from simply looking for individual doctors to hold accountable for poor outcomes.

On the other hand, clinician performance, like any other field of human endeavour, varies in the level of competence attained and demonstrated. This level of competence is largely managed through professional development and peer review at the local level; supported by professional Colleges and the Medical Board of Queensland.

It is estimated that, over any 5 year period, up to 6% of Doctors will have serious concerns raised regarding their competence and the consequential impact that this has on the safety of their patients (5). This equates to around 1% per year who may need a more formal approach to quality assurance.

Of course, the corollary is that 99% of doctors will not have such issues. Moreover, even in the 1% of cases where concerns are raised, not all of these concerns will be substantiated. For these doctors there is an ongoing need for quality feedback to assist them as professionals to maintain their high standards.

What is the issue that needs to be addressed?

The community has clearly indicated that it wants **safe doctors**, and to be confident that performance issues are being thoroughly and appropriately managed, and if concerns are not substantiated – they can be reassured.

On the other hand, doctors want a **fair system**: One that supports the "99%" of good practitioners; and if concerns are raised – they want those concerns fairly and impartially assessed. In cases where deficits in skills, knowledge or rehabilitation (rather than suspension and disciplinary action) to be the primary focus; provided this can be achieved without compromising patient safety and quality.

What is wrong with the current approach?

National and International research has identified that traditional methods of performance management have proven difficult to apply in clinical settings, particularly in regard to medical staff.

Our existing processes are complex, ill-defined and poorly understood by doctors, managers and external stakeholders. They frequently lead to adversarial outcomes which do little to assist the doctor.

Sometimes – in an attempt to avert conflict – avoidance behaviour is seen, including resignation and relocation of the doctor – only to have similar issues resurface in a different time and place. Regrettably, this is so in most jurisdictions worldwide.

A new focus – a new framework

Internationally there is a view that a new focus is required which will both support continuous improvement for the "99%" and also manages individual concerns when they are raised regarding the "1%". Any new framework should:

- be explicit, predictable, transparent and early;
- focus on gaps in knowledge, skills, abilities and behaviours; and
- be supportive and respectful with an emphasis on remediation at an early stage wherever possible.

In response, this draft framework has been produced which emphasises these views. Alongside the **existing** legislated investigation pathway, the proposed framework outlines two other key elements:

- A **clarified** methodology to provide better support for Clinician Quality Feedback (CQF) and local peer review for the "99%";
- A new Assessment and Remediation path which focuses on assessment, with a view to remediation of any identified areas for improvement for the "1%".

There is a deliberate attempt to move to a pro-active and preventative process in which collaboration and support are the hallmarks.

The Discussion Paper

This Discussion Paper and its associated "Quick Start" guide have been produced on a "without prejudice" basis. They outline a possible future framework in which it is hoped the above vision can be achieved.

There is a deliberate attempt to move to a pro-active and preventative process in which collaboration and support are the hallmarks.

The focus of this document is on full time and visiting medical staff within Queensland Health. Whilst many of the concepts may be applicable to other clinical staff, the scope of this document is limited to medical practitioners.

For ease of use and clarity, this Discussion Paper uses flow-charts to outline the key steps in the process.

Importantly, achieving this vision may require the development of specific new training for Case Managers and other Assessors. Identification of appropriate resources may be required to support both Assessment and Remediation. Finally, it is likely that ongoing work will be required to refine and add to the techniques described, based on local and overseas research.

Acknowledgement

A large amount of work has been done in this area over the past few years. In particular the work done in the UK (by the National Clinical Assessment Service, part of the National Patient Safety Agency within the NHS) has been drawn upon heavily in conjunction with work being done in NSW and Victoria, as well as a large body of work being done in Queensland.

Discussion Points & Feedback

Your feedback is requested: both in terms of the appropriateness of the vision and methodologies outlined, along with any key challenges which will need to be addressed in order to achieve the desired outcomes.

A number of discussion points are included in this document, and formal submissions are invited on these, or any other matters relevant to the Project.

Discussion Points:	**For ease of identification, the discussion points are formatted on a grey background and are boxed like this.**

Feedback should be directed to the Project Officer:

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The need for a "Safe Doctors – Fair System" Framework

The safety and quality movement in healthcare has progressed rapidly in recent years. Drawing parallels from lessons learned in other industries such as aviation, there has been a focus on systems issues as the underlying cause of error in many cases.

Patients and clients accessing healthcare have a legitimate expectation that their treating clinician's performance is at or above a minimum standard and that this performance is assessed and monitored on an ongoing basis much in the same way that a passenger of an aeroplane expects that the pilot is regularly assessed with regard to performance.

As indicated above, our existing processes are complex, ill-defined and poorly understood by doctors, managers and external stakeholders.

This issue is not specific to Queensland or Australia. In the keynote address of the 4th National Safety and Quality conference held recently in Sydney, Dr Lucian Leape indicated that, throughout the world, every hospital has doctors whose performance is a concern, and our methods for dealing with such doctors are unsatisfactory. Typically our processes take too long; we ignore early warning signs; and when we do act, it is totally reactive. He described it as a "non-system" which is "implicit, personal and punitive" – an all-or-nothing approach. (1).

There is a clear need for a framework which:

- is explicit; predictable transparent; and early;
- focuses on gaps in knowledge, skills, abilities and behaviours; and
- is supportive and respectful with an emphasis on supporting continuous quality improvement at the individual and clinical unit level, and
- provides for remediation, rather than discipline, where issues persist.

Historical Approaches to Clinician Performance Issues

Current legislation provides for a default disciplinary pathway. This is described in Acts of parliament, Policies and Industrial Relations Manuals.

Without an alternative approach, the management of such issues generally results in either an adversarial process – or in avoidance behaviour: including resignation and relocation by the doctor; only to have similar issues re-surface at a different time and place – neither of which leads to rectification of the underlying issue.

This paper attempts to do two things:

1. To outline in more detail how a preventative process driven by doctors at the coal face could be better supported;
2. To provide an alternative to the adversarial pathway – that of a clinical assessment and diagnosis of the underlying issues with a view to providing treatment for recovery and remediation wherever possible, whilst underscoring the primary goal of ensuring patient safety.

UK Lessons

Within the United Kingdom's National Health Service (NHS) a National Clinical Assessment Service (NCAS) has been established to coordinate the management of clinical performance and remediation and to reverse the large number of suspensions of medical staff which has occurred following the Bristol Royal Infirmary Inquiry. According to the NCAS there has been a tendency in the UK to use suspension as the main tool in managing clinician performance with little focus on remediation and rehabilitation. (2)

To address this issue, the NCAS established a process of detailed assessment of a doctor's performance and their "Back on Track" program has recently been launched and certain aspects of that approach have relevance to Queensland.

They identified two major shortcomings:

1. The adversarial and punitive nature of an approach which has suspension as its only tool is almost certain to result in early warning signs being overlooked or ignored until the evidence for action is overwhelming. This has significant patient safety ramifications, and it could be argued that, rather than protecting patients, such a system may have the opposite effect.
2. Such an approach fails to address the key issues including the shortage of doctors; limited alternative career pathways; the cost of suspension etc.

Formal Reports

Recent formal reports in the wake of the issues at Bundaberg both made reference to the issue of clinician performance management and remediation.

In particular, the reports question the process of management of underperforming doctors when these concerns are raised, and also outline several areas where the proactive processes of individual clinician quality improvement and peer review could be supported better.

Forster Report 2005

The Queensland Health Systems Review (3) recommended that:

- "Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis should be developed and implemented with the support of the Patient Safety and Clinical Improvement Service and involvement of clinical leaders." (Recommendation 9.7)

- "Clinical audit (including routine death review) should be a routine activity for all clinicians, clinical networks and services. The necessary tools, resources, information systems and support should be developed and made available to facilitate this activity." (Recommendation 9.10)

Davies Report 2005

The Queensland Public Hospitals Commission of Inquiry (4) outlined numerous aspects of clinician performance management that could be improved.

Section 6.202 of the report states that "there are a number of measures aimed at maintaining clinical standards in hospitals, namely:

- Credentialing and Privileging;
- clinical audit and peer review, including morbidity and mortality meetings;
- the Service Capability Framework;
- the use of College accredited training posts;
- safe working hours for staff;
- continuing medical education;
- complaints and incident management systems; and
- a 'critical mass' of appropriately experienced peers."

The lack of a 'critical mass' is especially relevant to smaller hospitals and solo practices including many Medical Superintendents with the Rights of Private Practice. Even in the larger regional hospitals, individual units frequently have only 2 or 3 specialists in a particular department, and this can limit the ability to conduct effective peer review.

The Potential Scope of Clinical Performance and Remediation

In the UK, Sir Liam Donaldson found that in any 5-year period, approximately 6% of doctors will have serious performance concerns; the management of which calls for assistance from outside the local clinical unit or trust. (5) Assuming that Queensland Health has a similar proportion, the following would apply:

Queensland Health had 4,949 doctors as at the end of August 2006. (6)

Class	Class Description	Headcount	FTE
20RMO	Resident Medical Officer	868	863.76
20MRG	Medical Registrar/Prin House Officer	1,622	1,573.26
	Total Junior Doctors	**2,490**	**2,437.02**
20MED	Medical Senior Officer	291	246.40
20MMO	Medical Staff Specialists	1,129	1,019.60
20MOR	Medical Officer (Right of Priv Prac)	13	11.00
20MSP	Medical Superintendent	113	106.72
20PSM	Medical Officer - Public Service	16	14.74
	Total Senior Doctors (Staff)	**1,562**	**1,398.46**
60VMO	Visiting Medical Officer	99	30.34
60VOS	Visiting Oral Surgeon	8	1.48
60VSU	Visiting Specialist	790	239.69
	Total Visiting Doctors	**897**	**271.51**
	All Medical Staff	**4,949**	**4,106.99**

No data were available to quantify the number of doctors within Queensland Health where performance has been found to be deficient, however assuming that the rate in Queensland is similar to that in the UK, this would equate to 297 doctors.

NB: Whether these proportions and the definitions used to identify them apply equally in Australia has not been tested.

To manage such a significant challenge, a risk management approach is required. In order that this be approached on a uniform basis, it is proposed that a method of coordination along the lines of the service provided by the National Clinical Assessment Service in the UK be established, but be based in the existing Area Clinical Governance Units. (See further discussion below).

Clinicians and Managers

Discussions with local clinicians and managers have indicated a strong desire to support ongoing quality improvement and peer review initiatives; and where more serious concerns are raised, for a consistent, fair and objective process, focussing on remediation and rehabilitation wherever possible. This should be underpinned by the principles of procedural fairness and natural justice and enjoy broad stakeholder support. The approach should be transparent, yet respectful of the people involved.

Stakeholder Support

Without the support of the key stakeholders, such as the AMA, Colleges, the Medical Board of Queensland, as well as industrial and professional associations; such an ambitious project would fail.

Significant consultation is needed in order that a collaborative approach can be undertaken and the knowledge and wisdom from those organisations and their leaders can be incorporated into this framework as it develops.

We are grateful for the many suggestions already made and incorporated into this draft of the framework. Your ongoing help and assistance is requested and your feedback would be gratefully received at any time.

Discussion Points

Discussion Point 1.	**Is there support for a system which enhances individual clinician quality improvement and unit-based peer review; whilst also providing for an assessment and rehabilitation framework for the more significant cases?**
Discussion Point 2.	**As the networks are not currently structured to cover every specialty and sub-specialty, what should occur where there is no specific network?**
Discussion Point 3.	**Are there reasons to believe that Queensland Health's exposure would be different from the figure of 6% in the UK? Does this match local experience?**

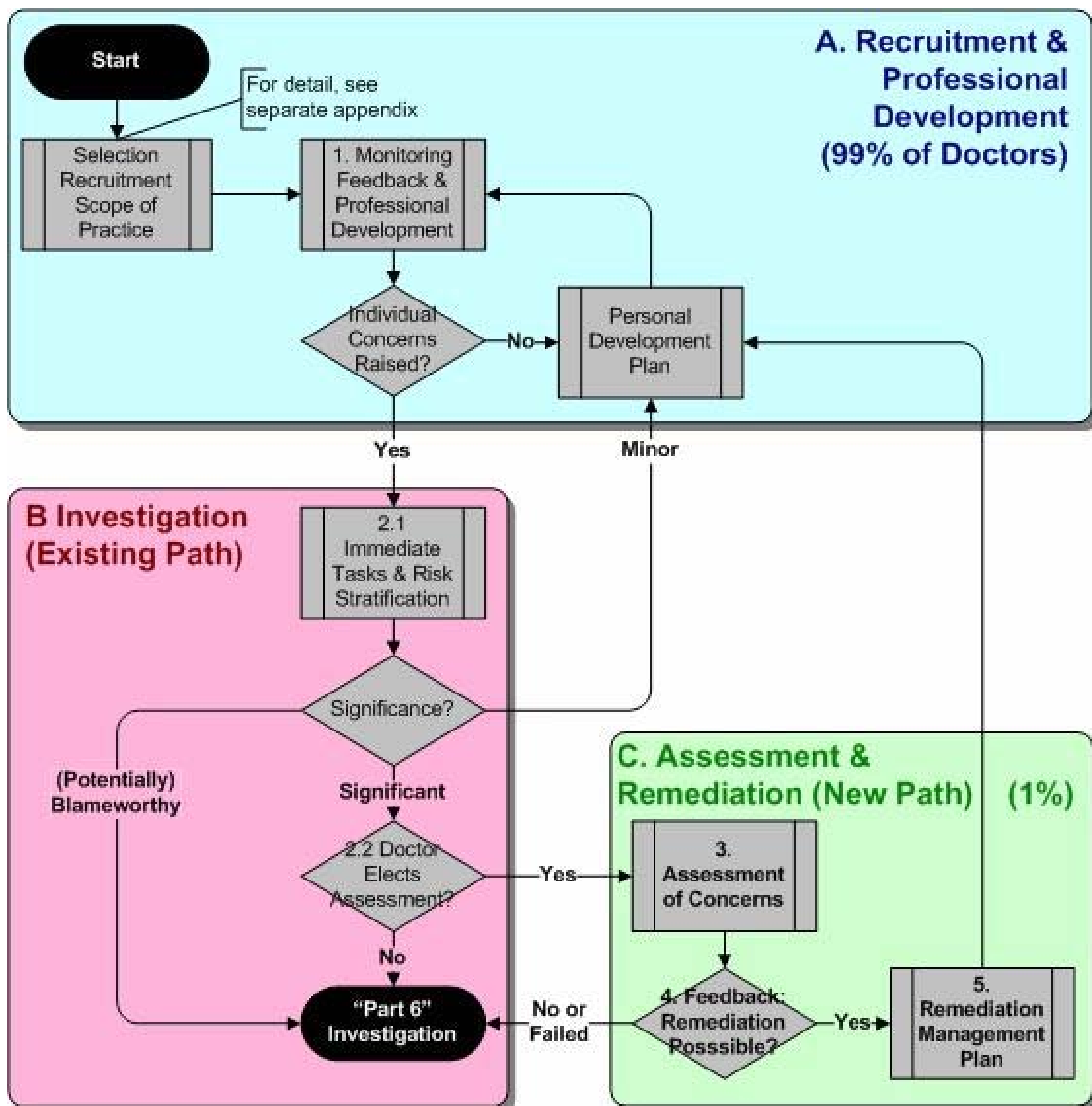
Proposed Overall Framework

The following diagram represents the overall framework for the management of Clinical Performance using the "Safe Doctors – Fair System" approach. Elements of the proposed framework will be discussed in more detail in their own sections; however the summary diagram outlines three broad domains:

A. Professional Development, including Recruitment and ongoing feedback

B. The existing Investigatory Pathway – based on the provisions of Part 6 of the Public Service Act (1996) and Part 6 of the Health Service Act (1991). (See Appendix).

C. A new Assessment and Remediation pathway as an alternative to formal investigation.



2 Recruitment and Professional Development

Essential to maintaining quality medical staffing is a robust recruitment process supported by a strong emphasis on continuous quality improvement. This in turn is facilitated by timely and accurate feedback to support peer review and good clinical governance at the local unit and facility level.

2.1 Recruitment, Selection and Scope of Clinical Practice determination

Much of the process of recruitment and ongoing performance appraisal and development is covered in a range of other Queensland Health policy documents.

This aspect is outside the scope of the "Healthy Doctors" project; however some suggestions regarding this area have been made in the separate Appendix which can be read in conjunction with this document.

Broadly, this paper recommends strengthen the involvement of professional colleges in all senior appointments, and outlines a more detailed framework for managing and defining the Scope of Clinical Practice (SOCP)[1].

2.2 Clinician Quality Feedback

A key component of ongoing continuous quality improvement is the provision of timely and accurate feedback to the individual clinician.

Organisational support for such a process can assist doctors and clinical units in their own quality improvement activities and peer review as well as identify areas for professional development.

One such support which Queensland Health could provide to assist local self-management involves collating information from a range of systems and inputs to create a "Performance Intelligence System" as described in the literature by Griffiths (7).

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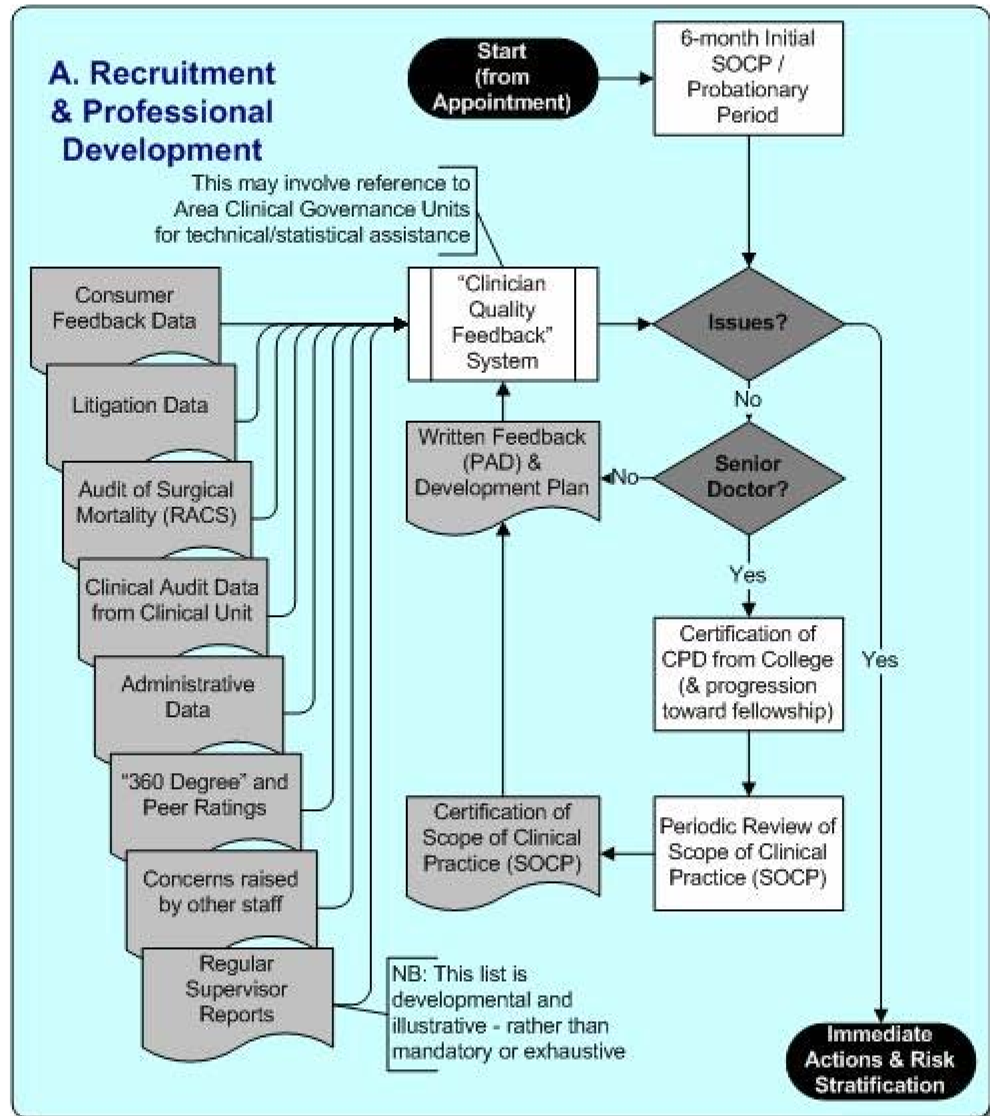
[1] Scope of Clinical Practice (SOCP) was formally called "Clinical Privileging". The term Scope of Clinical Practice has been used throughout this document in line with the National Standard as defined by the Australian Council for Safety and Quality in Health Care in their Standard for Credentialing and Defining the Scope of Clinical Practice

The inputs to such a process should be as broadly based as possible. The flow-chart below outlines some illustrative components of a "Clinician Quality Feedback" (CQF) System:

NB: For 99% of Doctors, this is the only relevant section of this paper!



It should be noted that, in the absence of significant issues being identified, this stage remains a "closed loop" system with ongoing (annual) feedback in the form of a Performance Appraisal and Development assessment, incorporating a Personal Development Plan.

2.3 Automatic Compliance with HQCC Act

As an additional by-product, the formalisation of this approach simplifies and guarantees compliance by individual clinician providers with s20 of the Health Quality and Complaints Commission Act 2006:

> **20 Duty of provider**
>
> (1) A provider must establish, maintain and implement reasonable processes to improve the quality of health services provided by or for the provider, including processes—
>
> (a) to monitor the quality of the health services; and
>
> (b) to protect the health and well being of users of the health services.

2.4 Gap Analysis

The flowchart outlined above is analysed in terms of gaps, and proposals for improvement.

Element	Gaps	What has been done Elsewhere?	Proposal
6-month Initial SOCP / Probation Review at 6 months.	Many doctors are not provided with formal review at the end of their probation period.		For Senior doctors, ensure that clinical privileges expire at the end of the probation period as a "forcing function" to assess performance at that time.
Audit of surgical mortality (RACS).	This is currently under development / negotiation between QH and RACS.	**WA** and **RACS** have pioneered the use of surgical mortality review in Australia.	When implemented, the RACS review of surgical mortality will assist in routine and ad-hoc assessment. An approach to non-surgical mortality should also be developed in parallel.
Data from clinical unit audit.	Most clinical units struggle with performing unit audits in a robust way, partially due to a lack of uniform deployment of audit systems and lack of clerical support with statistical skills.		A project should be established to analyse the available systems, and to encourage one or more of these to be implemented, and resourced adequately to enable data entry, as well as analysis and reporting at the unit level.
"360 Degree" and Peer Ratings.	Peer ratings have not been utilised until recently in QH and then predominantly at senior levels.	Use of Peer ratings has been suggested as being appropriate to evaluate clinician performance in the **US**. (8)	Provide the tool available in the Appendix document as one of the options for inclusion in a CQF System and also used subsequently if an analysis is performed.

Element	Gaps	What has been done Elsewhere?	Proposal
CPD Certification (senior only)	Not all colleges undertake annual certification. Not all doctors are associated with colleges. Current CPD is not routinely checked. Annual checking (Credentialing) may be required. Lack of evidence regarding the effectiveness of the current CPD processes.		Ensure annual certification is forwarded from colleges where available. Ensure 100% of senior doctors are involved with undertaking CPD with at least one college. Monitor progression toward fellowship for Deemed Specialists and other IMG senior doctors at Scope of Clinical Practice committees.
Periodic Review of Scope of Clinical Practice (SOCP).	No external re-certification examinations are done post fellowship in Australia.	**US:** Requirement for re-certification on a periodic basis (5 years). UK and Canada also.	Review of Scope of Clinical Practice and Annual PAD should be aligned.

2.5 Key Issues

The establishment of a "Clinician Quality Feedback" System is problematic for two reasons:

1. Small volumes generally mean that individual components are rarely statistically significant – and virtually all methods to monitor performance have limitations in one aspect or another. In combination, however they provide a broad basis for ongoing monitoring, feedback and to facilitate the doctor's own personal development planning as well as clinical unit peer review.
2. Measuring doctors' performance is problematic as they seldom work alone according to Griffiths (7). Rather than relying solely on a statistical performance assessment relating to an individual he describes a concept of performance intelligence as "the science and art of knowing when and where to act".

2.5.1 Elements of a broadly based "Clinician Quality Feedback" (CQF) System

The following elements should be viewed as suggestions, rather than a definitive list of components of a system of feedback to clinicians:

2.5.1.1 Use of Administrative Data for Clinical Audit and Statistical Analysis

Since Wennberg and Gittelson (9) identified several-fold variation in the rates of tonsillectomy and hysterectomy across contiguous counties in Vermont, much use of statistical administrative data has been made in the study of outcomes and demand for surgery, and the role that individual practitioners play in the outcomes. In general, however, involvement of clinicians has been less than might be anticipated (10).

Recent analysis within Queensland Health has questioned the validity of utilising administrative data ***in isolation*** to monitor complications and morbidity. Concerns have been raised from a statistical perspective, and although the strongest concern relates to external reporting, the usefulness of such data may be limited even for internal monitoring purposes. (11, 12).

On the other hand, in their review of the guidelines produced by the Royal Australasian College of Surgeons' Surgical Audit Taskforce, Watters, Green et al. (13) recommended *"wherever possible data for audit should be derived from a hospital information system as this will save a great deal of effort once the fields to be downloaded have been selected."*

The issue can not be avoided, however, due to ongoing public and political expectation to utilise and report such statistics. Further, it is likely that with increasing use, the information and the interpretation of that information will improve.

Importantly, whilst such data sources should not be relied upon as the only measure of performance, they have a place as one of a ***suite of inputs*** to a mature "Clinician Quality Feedback" System.

2.5.1.2 Clinical Audit

Watters, Green et al. (13) noted that many surgeons find it difficult to conduct clinical audits within their departments. He stressed that any minimum data set collected should not only contain the numbers and types of patients treated, and procedures performed, but also complications and outcomes data.

A range of tools were commented upon, and the importance of the audit meeting was highlighted, noting that: *"it is important that there is not only a chairman's report, but that the report is forwarded to an appropriate multidisciplinary group such as clinical risk management or safety and quality committee. There needs to be a surgical presence on these committees to ensure both representation and feedback to the surgical group. A surgical representative also needs to be involved in investigating the events where this is required, finding solutions and communicating any recommended changes to practice".*

With regard to confidentiality, they reinforce that *"any events concerning an individual patient care would be readily obtainable through the case records and are thus discoverable under freedom of information in any case. The chairman's report does, however, have to be written recognising that what is written down and recorded is discoverable. It should avoid speculation and accusation."*

Although Watters, Green et. al. refer specifically to surgical specialties, their comments are equally valid for other disciplines.

2.5.1.3 Complaints

Analysis of complaints, particularly where they relate to individual performance, can indicate deficits in interpersonal skills as well as clinical knowledge and abilities; and should be a regular component of any feedback system. There are few arguments against including this information in a balanced routine review process particularly as a sensitive marker of communication and empathy.

Griffiths also makes reference to the use of standardised complaint systems in the UK indicating that "it rapidly becomes visible if a particular consultant or GP has more complaints than would be expected" (7).

2.5.1.4 Use of Litigation as an Indicator

Research in the USA repeatedly finds a poor correlation between medical negligence and malpractice claims with only 3% of documented negligent injury resulting in litigation. Further, where litigation was successful the majority had no discernible adverse event, and nearly a quarter had an adverse event but no negligence could be demonstrated (14).

Litigation, however, may be seen as a useful marker for communication issues and therefore retains an important place in a broadly-based CQF System.

2.5.1.5 Use of Peer Ratings to Evaluate Physician Performance

The literature would suggest that it is feasible to obtain assessments from professional associates of practicing physicians in areas such as clinical skills, humanistic qualities, and communication skills. Peer ratings provide a practical method to assess clinical performance in areas such as humanistic qualities and communication skills that are difficult to assess with other measures. The separate Appendix document contains a representation of one such tool, which could be made available to local clinicians and managers. (8)

2.5.1.6 Adverse Events

Use of adverse incident data is controversial, as effective incident reporting systems focus on addressing underlying system issues rather than individuals. Many stipulate that no adverse outcome will come to any individual as a result of reporting. On the other hand, certain incidents may result from competency deficits.

The Clinical Incident Implementation Standard (15), and draft legislation to protect Root Cause Analyses specify "Blameworthy Acts"[2] which must be reported. Such incidents require investigation in a disciplinary model.

To some degree this paradox may be able to be addressed in the following way:

- Poorly performing clinicians rarely, if ever, have only one issue or incident as a marker (See discussion below).
- Where clinician performance is a genuine issue, a robust "Clinician Quality Feedback" System ought to have several alternative (ie non Adverse Event) indicators which could be acted upon.
- A "front-end" decision support tree, along the lines of that provided by the NCAS could be implemented as a prelude to data entry into the Adverse Events System: http://www.msnpsa.nhs.uk/idt2/(vdsokxmfuif0s245clppnyjx)/index.aspx

Therefore, the use of adverse event information to monitor individual clinician performance should not be required provided a broadly based "Clinician Quality Feedback" System is in place.

2.5.1.7 Use of Multiple Approaches to identify Multiple Concerns

In support of the above discussion, several international studies have reinforced the view that clinicians with quality issues generally have multiple concerns raised.

In an analysis of the first 50 assessments made by the UK National Clinical Assessment Service (NCAS) (16) – of the most serious cases referred to them – 40 (80%) had issues with aspects of clinical care, including clinical decision making, with the top 6 being:

- diagnoses;
- medical record keeping;
- adherence to agreed clinical policies;
- keeping up to date;
- history taking, consultation and examination skills; and
- prescribing.

Behavioural issues were the next most frequent issue with "communication with colleagues" appearing in 37 (74%), then "managing and organising" in 28 (56%), followed by "general behaviour", "communication with patients" and "leadership". The top health issue was "stress or anxiety" in 12 (24%).

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[2] A "Blameworthy Act" is defined in the proposed amendment to the Health Services Act (1991) (S38L) as: an intentionally unsafe act; deliberate patient abuse; or conduct that constitutes a criminal offence. In addition, S38N also includes situations where capacity was impaired by alcohol or drug consumption.

Significantly, in 40 cases (80%) there were 5 or more areas of concern. This demonstrates the multiple and complex nature of the difficulties that typify a poorly performing doctor.

Griffiths (7) points out that it is unusual for a failing doctor to appear as an outlier on only one of the measures of a good clinician and most fail several, (if not all) of the criteria used. He challenges the traditional notion that if clinical outcomes are adequate then almost all other issues can be forgiven. This, he points out, is partly due to the issue of statistical significance – the same issue which prevents us from relying entirely on statistical data also prevents its use to exonerate a clinician who is performing poorly in other domains.

Griffiths concludes by suggesting that routine administrative data, which is available easily, can be used as a screening tool and can assist local managers in adding weight to suspicions of poor performance. This is more robust when factors such as casemix and patient age are taken into account, but should not be used in isolation to confirm or, for that matter, to refute allegations of poor performance regarding an individual clinician. When combined with other "performance intelligence" however, a more fulsome picture emerges of which the data analysis may be a useful, but not sufficient element.

2.5.2 Issues with Statistical Analysis

The expectation of simple data metrics to separate good and poor performance is not generally borne out in reality. This was highlighted by Landon, Norman et. al. in their 2003 paper published in JAMA looking specifically at these difficulties in the US. (17)

2.5.2.1 US Physician Clinical Performance Assessment (PCPA)

The US now requires life long maintenance of certification which may include, amongst other items, a quantitative evaluation of professional practice termed Physician Clinical Performance Assessment (PCPA).

PCPA is based on complication rates and other outcomes measures including rates of adherence to evidence-based processes of care during their actual practice of medicine.

Lack of statistically robust, comprehensive; and evidence-based measures has limited this process, which has been compounded by a lack of clearly defined thresholds for acceptable care in many cases. For example, it has been estimate that a physician would need to have 100 patients with diabetes to achieve 80% reliability for most diabetes-related measures of quality.

Other confounders make this even more problematic: patients are not assigned at random to physicians – and the most difficult cases may all go to a particular doctor; increasingly physicians work as parts of larger and larger multidisciplinary teams therefore the relationship between an individual doctor and the outcomes generated are increasingly complex.

Finally they point out that the most effective methods of individual chart review are very costly, and even they do not have the 100% reliability that was once thought of such methods of assessment.

Once again, to mitigate this, they recommend taking information from as broad a base as possible, and utilise both statistical and non-statistical data to give a more robust picture.

2.5.2.2 Local Concerns re Understanding and Measuring Normal Distribution

Local concerns have echoed the issues raised in the US. Discussions with Executive Directors of Medical Services (EDMSs) reveal that applying a statistical approach in reality is done less frequently than might be anticipated. The analysis of statistical data is problematic for several reasons:

1. Obtaining credible and useful **data** has proven difficult
2. When data is able to be obtained, the **technical skills** required to convert this data to comparable benchmark information are not always held locally, or are not used frequently enough to maintain proficiency.
3. The process of performing the **analysis** is time consuming and is often deferred due to competing pressures.
4. When the skills are available, and an analysis is performed, managers often find **interpretation** difficult due to lack of agreed threshold information and uncertainty regarding statistical significance, particularly where small numbers are involved.
5. Information required to identify **sub-populations** or to normalise for specific patient populations is not readily available.

Notwithstanding the fundamental concerns regarding the use of such data, there is immense pressure to take into consideration the available statistical information. Assistance in the form of statistical analysis on a routine or ad-hoc basis is likely to prove useful, even if the analysis must be considered in the light of a more broadly-based approach to clinician quality feedback.

2.6 Discussion Points

Discussion Point 4.	**Should the use of statistical data be avoided prior to the above concerns being rectified and the data is considered validated – or should this data still be utilised as one component of a broadly based system, but not relied upon as a sole indicator?**
Discussion Point 5.	**Is there support for a comprehensive Clinician Quality Feedback System?**

2.7 Draft Recommendations

It is recommended that:

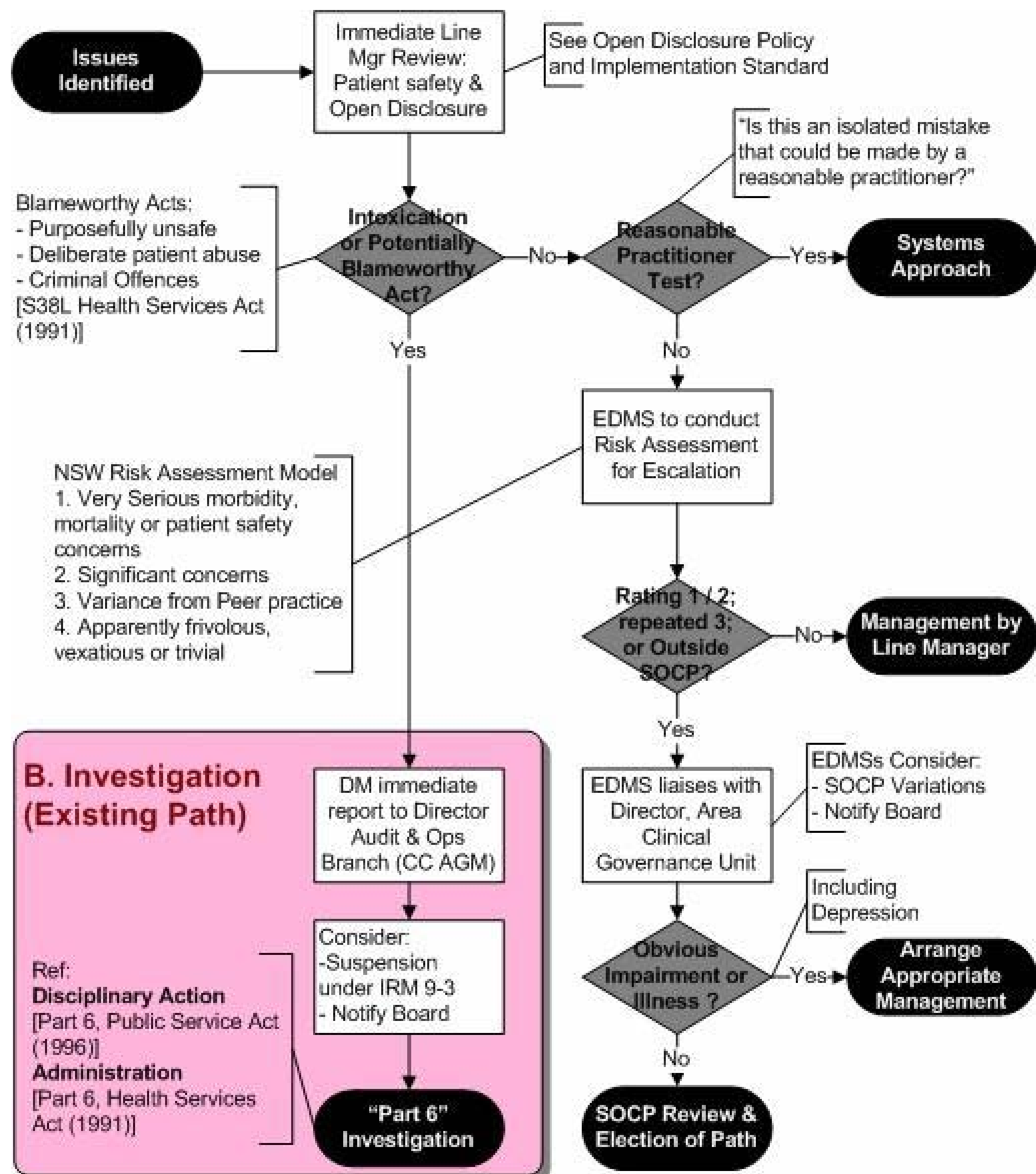
- the elements outlined in the "Proposals" column of the Gap Analysis (above) be adopted.
- state-wide development of a framework, tools and templates occur.
- "PRIME" Clinical Incident system should be modified to include a decision tree along the lines of that in use by the NHS.
- Area Clinical Governance Units be resourced to provide a central repository for easy reference to enable statistical analysis of Clinical Audit and Indicator Data to be compared against agreed national, international and college-based standards.
- districts implement a system of "Clinician Quality Feedback" which should include a number of elements within each of the following broad groupings:
  - Morbidity, Mortality and Audit, including specific requirements to look at Deaths, Complications, Complaints, Litigation as well as Statistical Analyses and any unexplained variances noted for further investigation.
  - Performance Appraisal and Development (PAD) and some formal or informal 360 Degree Feedback or peer rating system.
  - Scope of Clinical Practice (SOCP) Reviews, which should be both regular, (preferably annual) and also done on an ad-hoc basis.

3 Immediate Tasks; Risk Stratification; SOCP Review and Doctor Election of Pathway

3.1 Immediate Tasks & Risk Stratification

In the 1% of cases where concerns are raised, the local line manager (Clinical Director or Executive Director of Medical Services - EDMS) should make a rapid assessment of the circumstances to determine what, if any, immediate actions are required to ensure patient safety, and to "triage" the concerns.

NB: Isolated concerns rarely indicate a performance issue by themselves!



The above diagram and subsequent flowcharts also reconcile and merge the QH Clinical Incident Standard with a risk assessment methodology such as the NSW Model which is further described below.

3.1.1 Gap Analysis

As before, the flowchart is analysed in terms of gaps, and proposals for improvement.

In all aspects, patient safety is the first priority, and limitations to the scope of clinical practice should be made if they are necessary to avoid risks to patients (or staff).

When such measures are felt to be warranted they should be implemented on a "without prejudice" basis, and be implemented as quickly as possible to avoid the potential for further patient harm.

Element	Gaps	What has been done Elsewhere?	Proposal
EDMS to conduct Risk Assessment for Escalation	No formal system for risk assessment of individual clinicians currently exists.	**NSW** Risk Assessment for Escalation is published as part of their guidelines for the management of complaints or concerns about clinicians.	Incorporate the NSW Risk Assessment (as modified).
EDMS to consider if immediate variations to Scope of Clinical Practice are required and to Notify Medical Board	No indemnity for EDMS for a decision / recommendation to the DM to vary privileges as there is no overarching Queensland Legislation covering "quality activities" and IRM 3.8-3 specifically excludes doctors, whilst IRM 3.8-4 covers only clinical activities performed by doctors. Protection against reprisal is only provided for whistleblowers. Lack of clarity regarding threshold for notification of Medical Board.	**Queensland**: Other Acts Qld's Whistleblower's Protection Act, Health Services Act and the … **Commonwealth**: Health Insurance Act (1973) has such provisions. As an interim measure such protection could be afforded by including both clinical and non-clinical activities performed by medical practitioners in the indemnity provisions of IRM 3.8-4	IRM 3.8-4 should be amended to include both clinical and non-clinical activities performed by medical practitioners. The provisions of the Whistleblowers' Protection Act (18) or the Federal Health Insurance Act (19) should be incorporated into Queensland Health Services Act (20) to cover all quality activities, which should include clinician performance and development deliberations. Notification for all Severity Rating 1 or 2 cases (see below for more detail).

Element	Gaps	What has been done Elsewhere?	Proposal
Notification to Area CGU for Procedural Advice and Logging	The following elements need to be formalised: • central point for advice; • repository of templates and tools; • statistical support; • formal register/log of issues for resolution.	**UK** National Clinical Assessment Service provides centralised support, advice and (in the extreme cases) manages the entire process. **Victoria** – coordinated process by Medical Board	Establish these functions in each Area CGU – the three should work together to coordinate, provide backup for each other and ensure uniformity of approach.
Arrange Appropriate Management for Obvious Impairment or Illness	Current arrangements are unclear. There is a risk of commencing an investigation on a doctor with severe depression or another metabolic illness which would be un-necessary if the underlying illness is treated.	**Qld** – The Medical Board of Queensland has a good Impaired Doctors Program which pursues as non-punitive approach	Ensure that significant illness is identified early and treated before any other processes are put in place. NB this does not preclude limitation of SOCP to ensure patient safety, and may involve referral to the Board's Impaired Doctors Program or other specialist services. Feedback and monitoring is required.

3.1.2 Key Issues

Two key issues highlighted in this stage relate to Initial Risk Assessment and the provision of indemnity & protection for decision makers.

3.1.2.1 Initial Risk Assessment

The following table is taken from the NSW Health risk assessment for escalation that is published in their guidelines for the management of complaints or concerns about clinicians. The terms CE (Chief Executive) translate approximately to Queensland's Area General Managers; and Directors of Corporate Governance are approximately equivalent to Queensland's Directors of Clinical Governance Units. (21)

Severity Rating	Severity description used to assess a complaint or concern	Actions required following risk assessment of the Complaint or Concern.
1	Very serious complaint or concern arising from one or more events involving unexpected mortality or serious morbidity, gaps in clinical performance, an external event relevant to performance (such as a criminal conviction or termination of employment in another facility) or serious concerns by colleagues about the health and safety of patients.	1. Notify **[EDMS who will notify]** CE/DCG **[DM, DCGU]** immediately. 2. Determine whether notification to registration board is required, and any other relevant authority (eg Coroner, police). **[Recommended mandatory reporting of Severity Rating 1 to the Medical Board]** 3. Consider immediate suspension of clinical privileges in cases of suspected professional misconduct 4. Consider whether variations to clinical privileges are required.

Severity Rating	Severity description used to assess a complaint or concern	Actions required following risk assessment of the Complaint or Concern.
2	Significant complaint or concern, where there may be one or more events involving unexpected mortality or increasingly serious morbidity (SAC 1 or 2), and there may be a pattern of suboptimal performance or variation in clinical outcomes over a period of time.	1. Notify DCG **[DCGU]**. **[Recommended mandatory reporting of Severity Rating 2 to the Medical Board]** 2. Consider whether variations to clinical privileges are required. 3. Investigate **[ASSESS]**
3	Complaint or concern that the performance, practice or clinical outcome achieved by an individual clinician varies from peers or from expectations, but where there has not been any event involving unexpected mortality or serious morbidity.	1. Notify DCG **[DCGU]**. **[Recommended that Severity Rating 3 issues NOT to be routinely reported to the Medical Board]** 2. Management and Investigation as per AHS **[QH]** policy/procedure. 3. Manage outcomes in accordance with relevant policy or Award **[IRM]**.
4	Complaint or concern appears frivolous, vexatious or trivial.	1. Management and investigation as per AHS **[QH]** policy/procedure. **[Recommended that Severity Rating 4 issues NOT to be routinely reported to the Medical Board]** 2. Continue standard performance monitoring and management. 3. Notify DCG **[EDMS]**. of findings and actions.

Where there are reasonable grounds to suspect the conduct of a health professional may involve professional misconduct or unsatisfactory professional conduct the CE of the AHS or other Public Health Organisation must be notified as soon as they are identified.

Sections 99A and 117A of the **[NSW]** Health Services Act (1997) requires the CE to notify the relevant registration board of “any conduct of a visiting practitioner (or employee) that the chief executive officer suspects on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct under the Health Registration Act by which the registration authority is constituted”.

There would be benefits in having a parallel structure in Queensland and the above methodology could be simply translated to Districts and Areas as outlined above in bold, and these have been incorporated in the flowchart above.

Although in this paper the current ratings of 1-4 are used, personal communication from NSW has indicated the potential for confusion between Severity Ratings and Severity Assessment Code (SAC) scores. (15). Accordingly, if adopted, it is recommended that an A-D scale be used to avoid confusion.

3.1.2.2 Notification to Medical Board of Queensland

The table above outlines routine reporting of Rating 1 and 2 issues to the Medical Board of Queensland. Under a Memorandum of Understanding (yet to be developed) such notification might not necessarily result in the Board undertaking a separate investigation. An alternative could be established whereby such investigations or assessments could remain with the District/Area and continue to pursue a rehabilitative approach, but with agreed communication with the Board at set stages in the process.

3.1.2.3 Notification to Area Clinical Governance Unit

The role of the National Clinical Assessment Service (NCAS) in the UK is widely regarded as a positive initiative by clinicians, colleges, industrial organisations as well as managers within the NHS.

The NCAS provides a central referral point for logging and immediate allocation of a case manager to provide continuity and support for both the doctor, the management to ensure a positive outcome wherever possible.

Queensland Health has been strongly recommended to manage the most significant cases centrally, following the experience of the NCAS. The benefits of a centralised approach for the most serious cases include:

- having a critical mass of expertise to ensure consistency and compliance with agreed processes for the most serious cases;
- the establishment of a library of indicators and benchmark measures;
- a repository of expertise for advice on less significant matters;
- skills in statistical analysis, not able to be provided in most districts;
- an ability to log and track incidents state-wide to ensure timely completion of assessments.

The recently developed Clinical Governance Units have been established, at least in part, to undertake this role.

One proposal to achieve the above objectives, but avoid a centralised department would be for each Clinical Governance Unit to have identified staff who could undertake this role in close liaison with each other to form a "virtual" department, based in the three Area CGUs.

3.1.2.4 Indemnity & Protection for Decision Makers

It has been acknowledged that there are gaps in both the indemnity, and the protection from reprisal for medical officers who are performing non-clinical duties, in particular those associated with monitoring clinician performance and assisting with planning remediation. This involves both the review of objective data, and also necessarily involves both analysis and the formation of opinion.

Further, many individuals involved in this process report threats of legal or other sanctions from clinicians about whom issues have been raised. Current whistleblower's protection does not extend to those investigating such allegations.

Indemnity and other forms of protection could be managed either by policy, by legislation or specifically afforded in each Terms of Reference for assessment committees and Scope of Clinical Practice committees, and the relative merits are discussed below:

3.1.2.4.1 Policy Protection

Whilst policy change could be effected quickly (and is recommended), less protection, particularly from reprisal can be afforded by that means. Therefore it is recommended that legislative change be considered as an appropriate medium-term solution.

3.1.2.4.2 Legislative Protection

Legislative wording which could be used with little modification exists in a range of other Queensland and Federal Legislation when discussing related issues:

3.1.2.4.2.1 Whistleblowers Protection Act (1994) (Qld)

Section 41 of the Whistleblowers Protection Act (1994) makes reprisal (including the attempt at reprisal) unlawful – and this includes acts or omissions even where the reprisal is a substantial (but not the only) ground for the act or omission. (18).

3.1.2.4.2.2 Health Practitioners (Professional Standards) Act (1999) (Qld)

Section 386 of the Health Practitioners (Professional Standards) Act (22) outlines the protection of members, legal representatives and witnesses etc. While in the performance of their duties, board members, tribunal members and others assisting the board have the same protection and immunity as a District Court judge (when performing the functions of a judge) or as a person appearing before the District court.

Section 386A of the Act protects officials from civil liability for any act or omission made honestly **and without negligence** under the Act.

Section 287 of the Act provides the same protection as the Whistleblowers Protection Act (18) for people making complaints or otherwise giving information under the Act. Similarly sections 389 and 391 of the Act provide similar penalties for taking reprisals or for providing false or misleading information as the corresponding sections under the Whistleblowers Protection Act (18).

3.1.2.4.2.3 Health Insurance Act (Federal) 1991

Sections 124V to 124ZC of the Federal Health Insurance Act 1991 (19) outline protection afforded to activities which the Federal Minister for Health may declare a quality activity. In particular section 124ZB provides immunity from suit for members of assessment of evaluation committees provided that they are engaged in good faith in connection with a declared quality assurance activity, even where that conduct adversely affects any right or interest of another person, being a person who provides health services. The only exception is a proceeding in respect of a breach of the rules of law relating to procedural fairness.

3.1.2.4.3 Indemnity defined in "Terms of Reference"

As an interim step, the inclusion of indemnity in all Terms of Reference for all Performance Assessments and Scope of Clinical Practice Committees could be considered. Further, to protect those undertaking these Assessments, any threats made against those taking part in the Assessment should be regarded as a breach of the Code of Conduct and reporting of such threats be mandatory.

3.1.3 Discussion Points

Discussion Point 6.	**Should the NSW risk stratification approach be adopted as amended?**
Discussion Point 7.	**Is there support for the routine notification of Risk Assessment Severity Rating 1 and 2 issues to the Medical Board and the development of a Memorandum of Understanding to cover the reporting and communication requirements?**
Discussion Point 8.	**Would a "virtual department" comprising dedicated staff in each of the three Clinical Governance Units be a suitable approach?**
Discussion Point 9.	**Would policy or legislative change of the kind outlined above provide appropriate protection?**

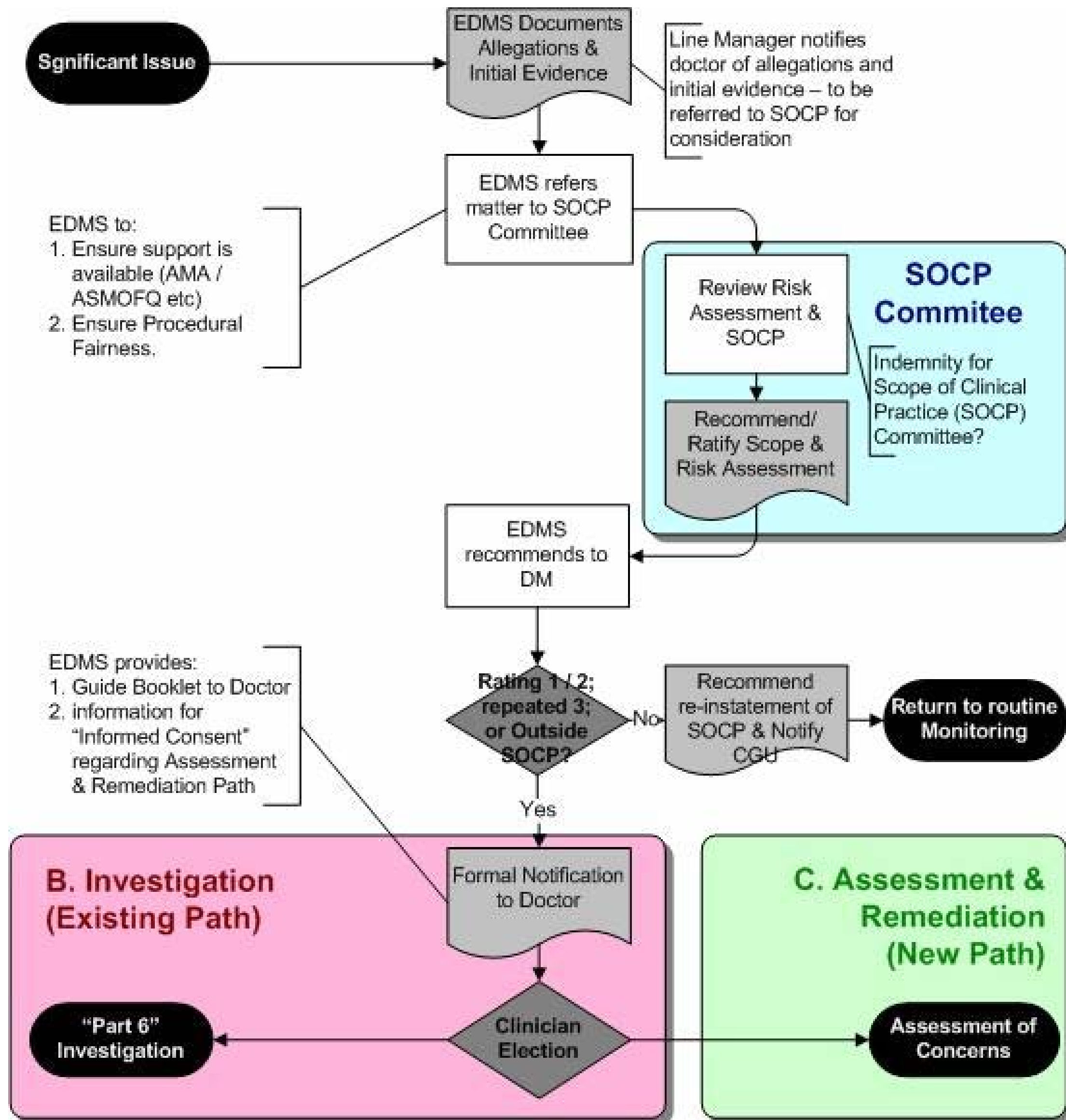
3.1.4 Draft Recommendations

It is recommended that:

- the NSW risk stratification approach be implemented (as amended) to assist managers in determining immediate actions as per the above flowchart.
- a "virtual" department be established based in the 3 CGUs
- legislation be drafted to provide protection for medical officers and other staff engaged in Clinician Performance and Remediation processes under the broad heading of a Quality Activity using wording which parallels that in other State and Federal Acts.
- as an urgent interim measure, IRM 3.8-4 be amended to include both clinical and non-clinical activities performed by medical practitioners.
- a 'blanket' indemnity be provided to all persons engaging in Scope of Clinical Practice committees as well as any Clinical Assessment Panels or other investigatory bodies.

3.2 SOCP Review and Doctor Election of Pathway

Once immediate patient safety needs have been addressed, the issue should be referred to the Scope of Clinical Practice committee for review – or a "second opinion". Referral provides a safety-net for the doctor and reinforces the role of the committee in ensuring patient safety and peer review.



Finally, the doctor needs to be provided with sufficient material for them to decide whether or not to elect to take the alternative Assessment and Remediation pathway as described later in this document.

Election is not compulsory – the current "Part 6" Investigation process is the default approach.

3.2.1 Gap Analysis

The gaps identified regarding referral to the Scope of Clinical Practice (SOCP) committee and the process of election of pathway by the doctor.

Element	Gaps	What has been done Elsewhere?	Proposal
DM/EDMS refers matter to Scope of Clinical Practice (SOCP) committee	Investigations are generally carried out separately to the SOCP committee. This furthers the adversarial nature of the process and also increases the risk of these functions becoming disconnected.		The proposed model reinforces and enhances the central role of SOCP committees in both Patient Safety and also monitoring and remediation as core elements of clinical governance at the district level.
Recommend re-instatement of SOCP & Notify CGU if risk assessment is found to be level 4 or "nil"	Lack of clarity regarding when/how/who to reinstate Scope of Clinical Practice (SOCP)		An integral role for the SOCP committee ensures that the 'loop' is closed, and formalises the end-point by reinstatement of the original (or a modified) scope of clinical practice.
Provide Clinician with Guide Booklet	No such booklet currently exists		Upon agreement of the overall framework, a guide booklet should be prepared and be given to clinicians at orientation, and again if a formal Performance Assessment is to occur.
Clinician Election	Currently the doctor does not have a choice in the method of investigation which can only be carried out under Part 6 of the Public Service Act (1996) and Part 6 of the Health Services Act (1991)		An 'informed consent' approach to allow the doctor to elect to follow an Assessment and Rehabilitation / Remediation pathway. Such a path would involve undertakings by both Management and the Doctor to implement recommendations for rehabilitation or remediation.

3.2.2 Key Issues

The key issue is the inclusion of an element of control by the doctor regarding the pathway and focus to be taken.

3.2.2.1 Election and "Informed Consent"

The implementation of a voluntary, non-punitive pathway should be done on the basis of an agreed approach involving commitments from both management, and also the doctor, to implement strategies to assist in remediation or rehabilitation of the doctor.

The overall goal is full re-instatement of unsupervised practice over a period of time, but with appropriate ongoing support structures being put in place.

At any time, the clinician can elect to have the matter handled as an investigation and/or disciplinary matter under the provisions of the Public Service Act (1996) and the Health Services Act (1991).

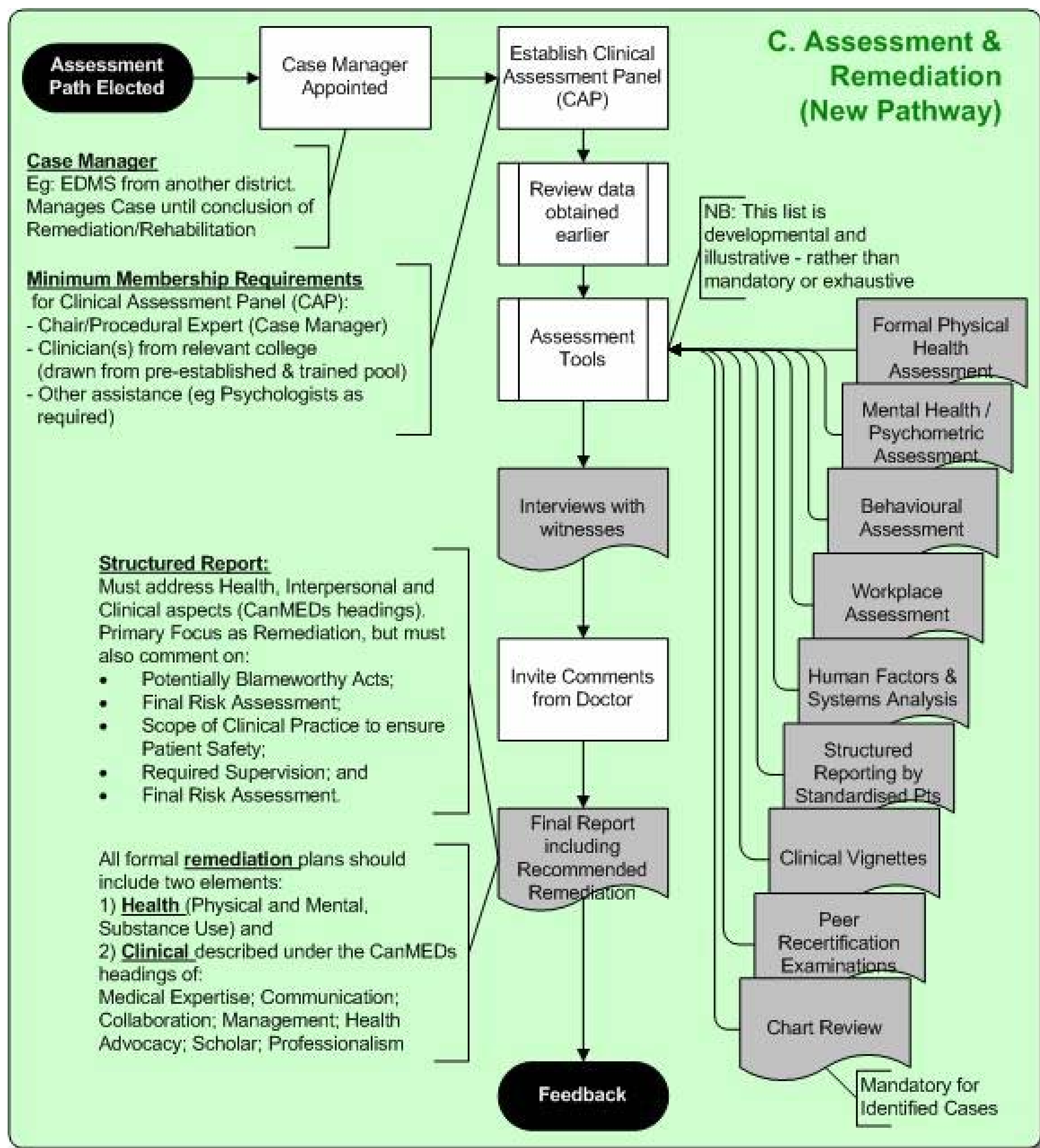
3.2.3 Draft Recommendations

It is recommended that:

- the flowchart above be adopted;
- standard templates be developed and a guide booklet be prepared and provided to all clinicians at orientation, or at the commencement of any investigation /assessment process;
- the role of SOCP committees be reinforced as outlined above, particularly with respect to the management of the "Healthy Doctors" framework;
- a "consent" sheet be prepared providing the doctor with appropriate information in order that they may make an informed decision regarding election of the assessment and rehabilitation pathway or to remain on the existing investigation and disciplinary pathway.

4 Conducting an Assessment of Concerns

This is the core phase of the new pathway of Assessment. A range of possible techniques are presented. Which of these is selected for any given assessment will depend, in part, on the issue presented, and the risk rating.



To avoid duplication, elements may be re-used to inform any subsequent "Part 6" Investigation if the Assessment/Remediation fails.

4.1 Gap Analysis

Several steps are done routinely and well by some managers, whereas others provide opportunities for further development, and for clarification of the roles of the Area Clinical Governance Units and the District Scope of Clinical Practice committees.

Element	Gaps	What has been done Elsewhere?	Proposal
Physical, Mental, Behavioural and Workplace Assessments	These are rarely performed with the exception of Medical Board processes for impaired doctors. The process to access such assessments is not clear. The reporting requirements and privacy considerations are not clarified.	The **UK** National Clinical Assessment Service and their Back on Track program focus, in the more serious cases, on an holistic approach to the entire clinician and their environment.	These processes be developed in conjunction with stakeholders and experts in these areas, and processes be established to enable such assessment components to be undertaken for all Risk Category 1 and 2 cases and for others as needed.
Human Factors & Systems Analysis	Tools such as those provided as part of the Human Error and Patient Safety (HEAPS) training are not universally used when clinician performance issues are suspected.	**Southern Area Clinical Governance Unit** routinely undertakes a HEAPS review to identify mitigating, and systems factors which provide added context and learning. **AMA** Safe Hours program is an illustration of systems factors impacting on individual performance.	All assessments should incorporate some form of Human Factors or Systems Analysis such as the HEAPS tool.
Other Assessment Tools	Chart review is generally undertaken in the more serious cases, however the methodology is not standardised. Other methods are uncommon in Queensland Health	Use of Structured Reports by “Standardised Patients”; Abstraction of Medical Records and “Clinical Vignettes’ provide a broader approach which may be utilised as described below. (23) **UK** NCAS does **not** use chart reviews as they feel the methodology of selecting known poor outcome cases has never been statistically validated – they utilise them only to ensure patient safety & open disclosure has occurred.	Develop standard criteria for selection and analysis of charts. Investigate the use of structured reporting by standardised patients, and “vignettes” to complement the current range of techniques available (see below). Mandate chart review for all identified cases (ie those raised by complainants etc) for patient safety and open disclosure purposes.

4.2 Key Issues

4.2.1 Detailed "How To" Manuals

Each of the listed steps needs to be accompanied by a detailed "how to" manual written by experienced personnel with appropriate mathematical and statistical input as relevant. The UK model of having such a toolkit available on-line should be implemented over time. These should be developed in a modular way, and updated as improvements are identified[3].

4.2.2 Health and Behavioural Assessments

In the most significant cases in the NHS, and to a lesser degree in NSW and Victoria, health assessments and behavioural assessments are performed formally to assess the full picture. It is proposed that such assessments should be introduced in Queensland Health as an integral component of the non-punitive (remediation) approach to the assessment of risk level 1 and 2 cases.

Research into referrals to the NSW medical board for impairment show that whilst alcohol and drug misuse have traditionally been the most common reason for referral to the Board for impairment (over 50%) this has now been overtaken by psychiatric problems including mood disorders which now account for up to 80% of referrals. (24).

The types of impairment seen by the NSW Board vary with phase of career.

Common Problems	Student	Novice	Mature	Older
Usually Referred to Board	**(17-24)**	**(25-34)**	**(35-54)**	**(55+)**
Depression	×	×	×	×
Bipolar disorder	×	×	×	
Substance misuse	×	×	×	
Alcohol misuse/dependence		×	×	×
Anorexia nervosa	×	×		
Early psychosis	×			
Early physical and cognitive decline				×
Delusional disorder				×
Usually Not Referred to Board				
Anxiety disorders	×	×		
Adjustment to course	×			
Balancing career with family / interests		×	×	
Marital problems			×	
Lack of planning for life after medicine				×

[3] As components of the assessment may be required subsequently if remediation is not felt to be possible (or the doctor elects to revert to the investigation / discipline pathway) appropriate care and diligence will be required with regard to the collection and recording of evidence etc.

Doctors are at higher risk of depression than the general community because of factors such as personality characteristics (eg perfectionism, dislike of conflict, high expectations of self) coupled with high levels of responsibility at work on the one hand; and sleep disruption on the other. This is doubly important given the eminently treatable nature of many of these conditions.

In Victoria, such assessments remain voluntary on behalf of the doctor. Doctors retain the right to have the process ceased at any time and have the matter referred directly to the medical board.

4.2.3 Use of alternative assessment techniques

In the US, Peabody, Luck et al. (23) reviewed the use of clinical vignettes as a method for measuring the competence of physicians and the quality of their actual practice. These, combined with structured reporting by standardised patient (trained actors) and abstraction of medical records are increasingly used to augment the above approaches and should be included in any assessment process progressively as they are established and validated in Queensland.

4.3 Discussion Point

Discussion Point 10.	**Do you agree that Health Assessments and Personality / Interpersonal Skills Assessments should become an integral component of all risk level 1 and 2 Performance Assessments as outlined above?**

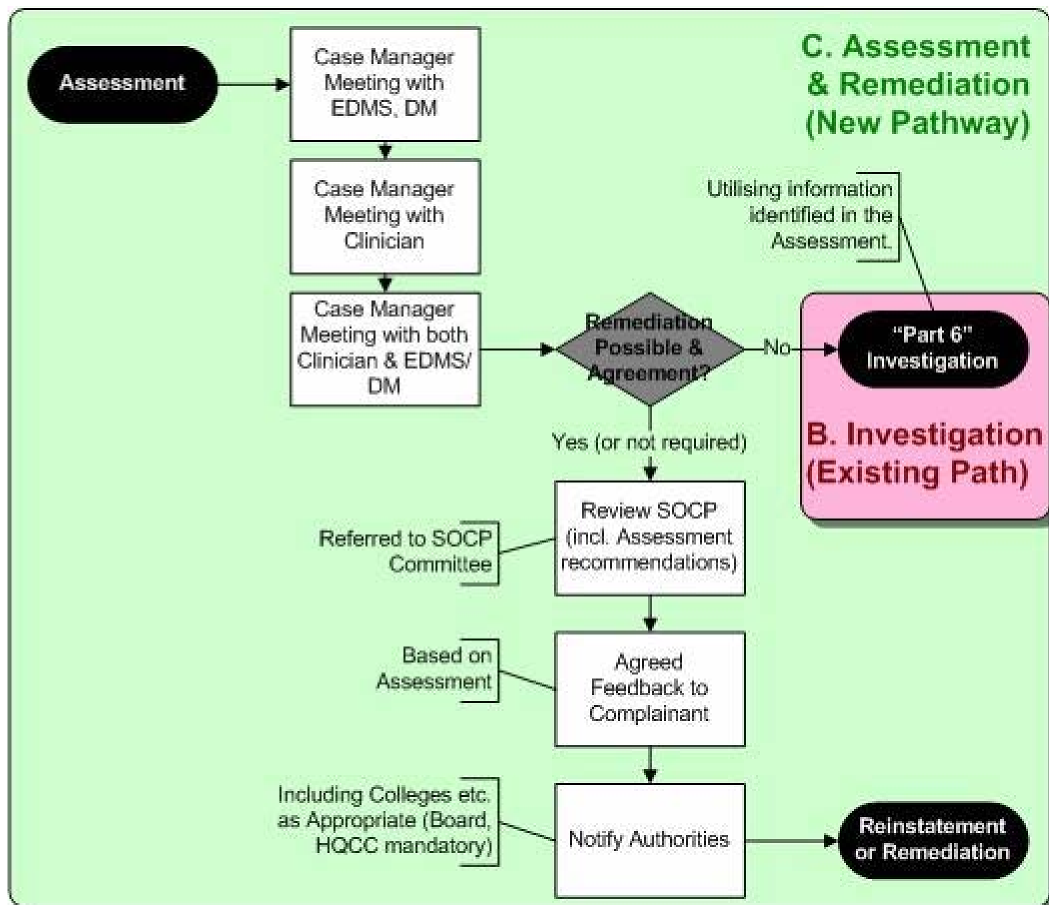
4.4 Draft Recommendations

It is recommended that:

- a series of "how to" manuals be progressively developed to assist managers in undertaking of the components of Performance Assessments.
- Health (Physical, Mental, Interpersonal) be included as integral components of all Area and District Clinical Assessment Panel (CAP) measurement of clinician performance.

5 Assessment Feedback

Once the Assessment is completed and a "diagnosis" is made, a series of meetings should be scheduled by the case manager with the referring management team; the doctor themselves; and then together to discuss the implementation of any remediation and rehabilitation options identified.



It is anticipated that in a substantial number of cases, no remediation will be required; however support may still be required for the doctor to re-integrate.

Feedback to the complainant is to be made with sufficient information to acknowledge the concerns raised, whilst maintaining the dignity of the doctor.

Communication with authorities would be covered by Memoranda of Understanding (MOUs). These would be published and also provided to the doctor at orientation, and again prior to election of the Assessment and Remediation Path.

5.1 Gap Analysis

This stage covers the feedback to the clinician and local EDMS regarding the findings of the Assessment and the proposed rehabilitation / remediation plan.

Element	Gaps	What has been done Elsewhere?	Proposal
3 Meetings to report feedback	Currently this is done by the EDMS or other Line manager if at all.	**UK** NCAS – use a similar approach to the one recommended	Implement a feedback process as outlined.
Agreed Feedback to Complainant	Feedback to complainants is not always performed		Agreed feedback would ensure that optimal levels of transparency whilst balancing appropriate confidentiality & dignity needs of the clinician.
Notification of Authorities & Colleges as Appropriate (Board, HQCC mandatory)	No clarification currently. No legislative responsibility for notification – as this falls to the registrant. Recent DG Memo (25) indicated circumstances where notification should be ***considered***.	**NSW** process has clearly delineated escalation process based on Risk Assessment. **UK** model is managed centrally, with MOUs between agencies to determine notification. **Victoria** is managed by the Medical Board for all significant cases.	The proposed model uses a combined approach – with risk stratification, logging with the Area CGUs It is also proposed that MOUs be developed with key stakeholders clarifying in the flowchart precisely what/when/how notification should occur.

5.2 Key Issues

5.2.1 Structured Feedback Sessions

Providing separate meetings with local management and also with the doctor (and their support person) any concerns can be clarified before the third meeting to plan remediation.

This has been found to be most successful by the NCAS as the case managers are seen to be impartial and have a focus on successful remediation. The technique has enjoyed good support from the individual doctors and industrial bodies as well as clinical directors and other managers in the UK.

5.2.2 Involvement of SOCP Committee in Feedback

As the SOCP committee will be oversighting the progressive re-establishment of independent clinical privileges, it is important that they be involved early in the feedback discussion.

5.2.3 Feedback to Complainant/Whistleblower

Where there was a specific complainant, agreement should also be reached about the feedback to them. Feedback should take the form of noting that the formal assessment process has concluded and that recommendations for remediation are being put into place.

Details should be sufficient to indicate that the issue had been taken seriously, and that Queensland Health (and the doctor) had gained learning from the process, however the dignity of the doctor should also be maintained.

5.2.4 Allowing for the Prospect of Failure

Not all assessments will result in remediation being possible, or agreement being reached, and formal investigation may be required.

This can occur for several reasons including (but not limited to) the following:

- The issue can not be remediated – for example: due to an intractable medical condition or due to behaviours / abilities which are not felt to be amenable to change.
- The Clinical Assessment Panel may be unable to complete their task due to frustration or lack of cooperation of the parties.
- The Doctor may request that the Assessment process cease.

Under such circumstances a “Part 6” investigation process will be initiated, and the elements of the assessment already completed, (including any draft or final report and recommendations made) will be forwarded to the investigator(s) who are appointed.

The investigator may choose to augment the information provided from the Assessment process, or may accept that information as sufficient to make findings on the basis of the balance of probabilities.

5.3 Discussion Points

Discussion Point 11.	**Do you support the 3-meeting process of feedback (involving the Case Manager) as described in the NCAS?**
Discussion Point 12.	**Do you support an approach of agreed feedback to complainants / whistleblowers which maintains the dignity of the doctor, whilst acknowledging the initial complaint and providing closure?**

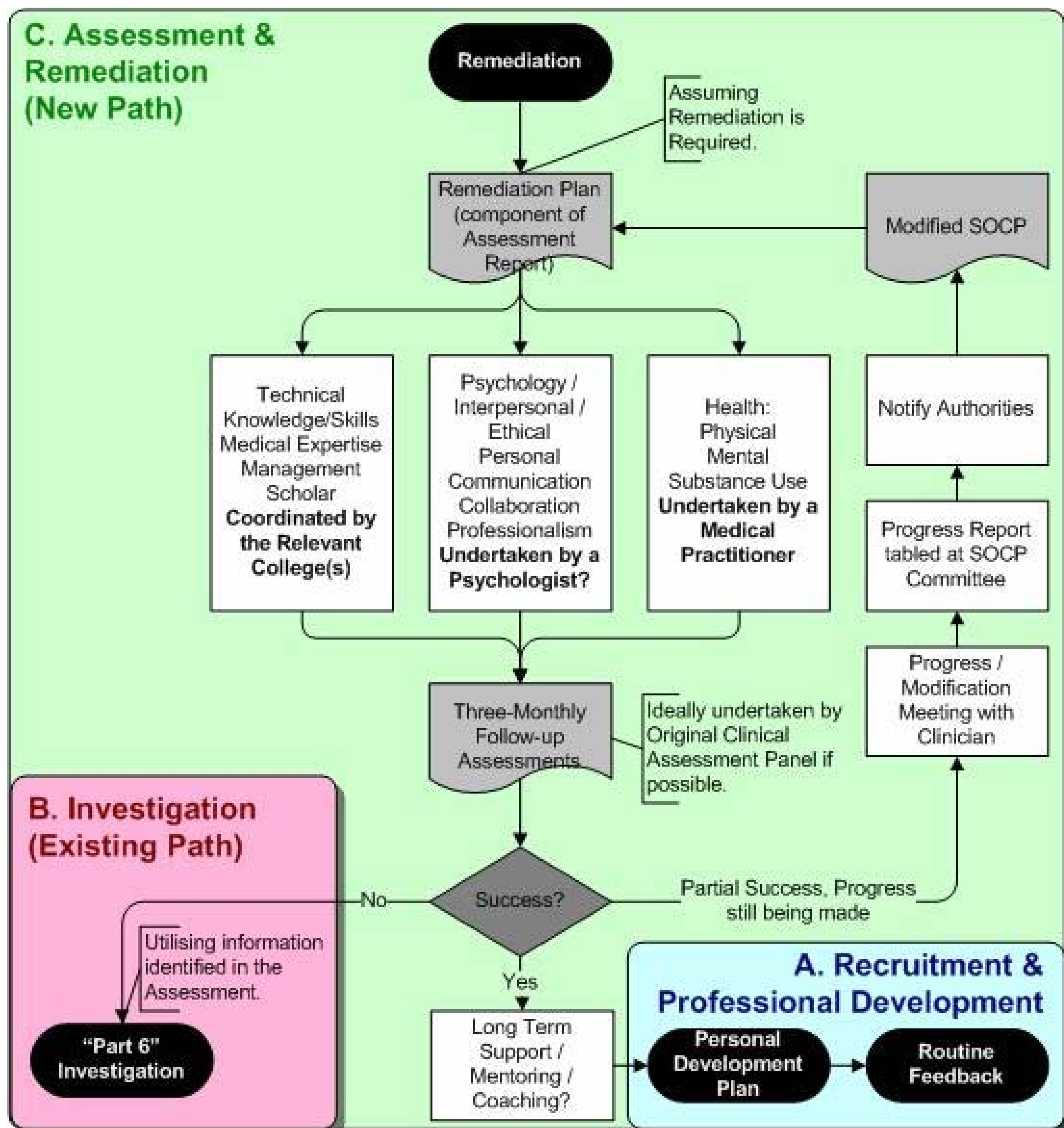
5.4 Draft Recommendations

It is recommended that:

- a three-meeting feedback approach be implemented following assessment and that this be lead by the case manager appointed to the assessment.
- SOCP committees receive early feedback and be involved in the progressive reinstatement of any SOCP which was restricted earlier in the process.
- feedback be provided to any complainants/whistleblowers at the conclusion of this stage in a sensitive manner preserving both the dignity of the doctor, and also highlighting the rehabilitative nature of the process and the learnings gained and providing some closure to the complainant.

6 Remediation Management Plan

Importantly, the primary goal of any remediation process should be to support clinicians to return to their chosen roles safely.



This is likely to involve considerable ongoing support, particularly in cases where the doctor is senior, and the issues identified require considerable assistance.

Even where the assessment reveals that no remediation is required, the doctor may benefit from support to re-enter the workplace and to re-establish professional relationships.

6.1 Gap Analysis

Significant work is required to further identify options in this area, and ongoing work will be required to continue to update these techniques in order to maintain best practice.

Element	Gaps	What has been done Elsewhere?	Proposal
Technical Knowledge/Skills; Medical Expertise; Management and "Scholar" issues (using the CanMEDs framework[4]) coordinated by the relevant college.	This is done largely on a "good will" and ad-hoc basis.	**UK** – formal MOUs have been developed between the National Clinical Assessment Service (NCAS) and the colleges.	Development of MOUs with the colleges may clarify possibilities and expectations to provide a more predictable outcome in such cases with a real focus on remediation rather than merely further assessment. Utilisation of Skills Development Centre increasingly as the technology for simulation continues to improve.
Psychology / Interpersonal / Ethical; Personal Communication; Collaboration; Professionalism issues (using the CanMEDs framework) undertaken by a Psychologist?	This has been done by engagement with private providers (eg Cognitive Institute) on an ad-hoc basis. No formal endorsement of such processes by stakeholders.	Significant effort is being placed into this area in the **UK** to augment the technical aspects of skills training. It is suggested that this may need to be ongoing for many months/years in some cases.	Further work is required in this area to look at options for formalising coaching for doctors in this area. (Management coaching currently being undertaken may be able to be used as a model).
Health Physical and Mental, including Substance Abuse.	Currently managed privately or via the Medical Board's Impaired Practitioner pathway. (if at all).	Significant focus in **Victoria**, **NSW** and the **UK** in this aspect of performance remediation. Medical Board of Queensland is looking at enhancing its impaired doctor program.	The establishment of MOUs with the Medical Board is seen as essential in this area to enable clear bi-directional communication and transparency, whilst retaining a focus on safety and remediation.

[4] The CanMEDS framework has been proposed in Canada as one of the ways to broadly define and measure clinician performance. (26.) The methodology defines seven roles that physicians and surgeons fulfil: (Medical Expert; Communicator; Collaborator; Manager; Health Advocate; Scholar; Professional).

A minor modification of the CanMEDs framework has been recently proposed by the Royal Australasian College of Surgeons to monitor progress of surgical trainees, with the initial role of "Medical Expert" being subdivided into three: "Technical Expertise", "Medical Expertise" and "Judgement – Clinical Decision Making".(27.)

Element	Gaps	What has been done Elsewhere?	Proposal
Three-Monthly Follow-up Assessments.	No current provision. Clinical reviews and supervisor reports are sometimes forwarded to colleges and not to management and vice versa.	**UK** – 3 month assessments. Criteria for success / failure are clearly specified.	Reviews should be undertaken at 3-monthly intervals by the same team who undertook the initial assessment. Results to inform the remediation process – either to monitor progress toward full reinstatement or to modify the remediation plan. Copy to be forwarded to the Board.
Long Term Support / Mentoring / Coaching	No current provision. Once technical aspects are found to be at an appropriate standard, little is done to re-engage the clinician from an "organisational re-entry" perspective.	**UK** – currently developing guidelines for long-term support. **UK** – Specifically addressing both the Clinical and Organisational components of re-entering the workplace.	As more is identified from the UK Back-on-track model, aspects of this may be able to be incorporated.

6.2 Key Issues

The key themes which emanate from the above are: the prospect of success; the concept of "organisational re-entry" and the question of cost, ie: who pays?

6.2.1 Prospect of Success

Central to the long-term success of this process will be the identification and publication of success statistics to encourage participation and ongoing support from stakeholders.

6.2.1.1 Private Sector Interpersonal Skills Courses

Private providers claim greater than 60% success in their intensive interpersonal skills course; in the absence of significant health issues, knowledge and skills are learnable (and re-learnable).

6.2.1.2 Outcomes following Assessment in the UK

In the previously mentioned review (16) of the 50 most severe cases managed by the National Clinical Assessment Service (NCAS) in the UK, 39 (78%) had either partially (in 28 cases) or fully (in 11 cases) implemented the recommendations of the assessment. In the remaining 11 the trust either referred the matter to the GMC or the practitioner had left.

Following analysis, 27 (54%) were regarded as successful (22 were working mostly with no restrictions and 5 were working toward that goal) with 3 having retired, and 2 were not specified. (Total of 64%)

The remaining 18 (36%) had issues such as: breakdown in relationships between the practitioner and colleagues; employer unhappy with the NCAS findings; or difficulties in finding a suitable clinical placement.

Given that this is a pre-selected group of the most problematic cases in the UK, these results are to be commended.

6.2.2 Separate processes for Clinical and Organisational re-entry

Within the Back on Track program the NCAS separates ***clinical*** re-entry (assuring clinical skills are satisfactory) from ***organisational*** re-entry (re-establishing the doctor in the organisational setting and colleague relationships). The former is managed in close collaboration with the royal colleges whilst organisational re-entry is undertaken by organisational psychologists.

6.2.3 Cost

Support programs are likely to require continued assistance and this may involve ongoing expenditure. Some thought needs to be given regarding the commitment to achieving this goal.

Similarly, the costs of such processes are yet to be determined, and more information is being sought from the UK's "Back on Track" program.

6.3 Discussion Point

Discussion Point 13.	**Are you aware of other "success stories" or techniques which might contribute to the options available for remediation?**

6.4 Draft Recommendations

It is recommended that:

- the above flowchart be adopted.
- Queensland Health adopts in principle an active remediation model as a policy initiative subject to analysis of relative costs.
- further research be undertaken to provide information regarding the costs of remediation, and the organisational re-entry component of the "Back on Track" program.

Conclusion

Once overall agreement is reached regarding the framework, further documentation of the various steps will be required, however it is prudent to seek feedback on the principles of the approach before further work is undertaken.

It is likely that this will be an evolutionary process as techniques are developed and improved.

Please feel free to add any further topics, and also to contribute comments or tools which may be able to be incorporated into either the framework or any resultant toolkit.

Thank you for taking the time to read this paper; and I seek your contribution by whatever means, even if only a brief comment indicating broad support.

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