

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by - JANET ATKINSON - 2001 Churchill Fellow

To examine initiatives taken by self-regulating medical registration bodies to protect the community from the doctor whose standard of professional performance is poor

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INTRODUCTION

The regulation of the medical profession in Australia is the responsibility of medical boards established in each state and territory under state/territory law. The profession is considered to be self-regulating because the majority of members of the boards are medical practitioners, usually in active practice. Boards also have as members community representatives and a lawyer. Members are usually appointed by the Governor in Council for fixed terms, mostly of three years. Boards report to their respective state Parliament through the state Minister for Health and are independent statutory bodies. The boards' processes are financed by annual registration fees paid by members of the profession.

The Acts of Parliament under which the medical boards are established typically express their main purpose as being to protect the public. The means by which this purpose is achieved is by providing for the registration of medical practitioners and conducting investigations into the professional conduct and fitness to practise of registered medical practitioners (see for example section 1 *Medical Practice Act 1994 (Vic)*).

The main functions of medical boards are therefore to assess the medical qualifications and character of persons seeking registration, to assess the professional conduct of registered medical practitioners either as the result of a complaint or on the board's own motion, and to assess the fitness to practise of registered medical practitioners whose ability to practise is affected by physical or mental health, incapacity, or alcohol or drug dependency. A board may take action in respect of a medical practitioner's registration as a result of professional conduct and fitness to practise investigations (eg cancellation, suspension, imposition of conditions).

The community is increasingly demanding reassurance from the medical profession that registered doctors remain competent and perform adequately and safely. There is growing concern that the powers of the medical boards, as outlined above, are insufficient to enable the boards to protect the community from the doctor whose standard of professional performance is poor.

The medical boards are considering how best to address this problem. At the time this Fellowship was awarded, no Australian jurisdiction had taken action in this area – Victoria and New South Wales were working on proposals.

Considerable work has been done in the jurisdictions visited overseas. Approaches include:

- peer review of doctors chosen from “at risk” groups or randomly selected, as in Canada;
- performance assessment of a doctor following receipt of a complaint, as in the United Kingdom;
- creation and dissemination of knowledge through “State of the Art” documents, national guidelines, National Health Care Registers and National Health Care Quality Registers, as in Sweden;
- feedback of data on adverse outcomes to health care providers, policy makers and administrators, as in Sweden and the Netherlands;
- renewal of registration being dependent on demonstration of fitness to practise, as in the United Kingdom and the Netherlands.

Acknowledgements

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EXECUTIVE SUMMARY

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Project Description: To examine initiatives taken by self-regulating medical registration bodies to protect the community from the doctor whose standard of professional performance is poor: including identification, establishment of standards for assessment, and development of remedial training programs.

To study the legislative framework underpinning such initiatives.

Places visited: Medical regulatory authorities in Canada (British Columbia, Ontario, and Quebec), the Netherlands, Sweden, and England.

Conclusions and Recommendations:

- All medical boards in Australia should have powers which enable them to protect the community from the doctor whose standard of professional performance is poor.
- There should be national co-ordination of initiatives taken by the medical boards in this area to ensure consistency of approach and scope.
- The goal of such initiatives should be to raise the standard of practice of the whole profession, not just that of the individual problem doctor.
- Programs should be educational rather than punitive or disciplinary.
- Monitoring should not be implemented without the provision of enhancement opportunities.
- Feedback to individual doctors should be integrated with the monitoring system.
- Information gathered in performance assessment should not be used in disciplinary proceedings except in certain limited circumstances.
- The bodies administering performance assessment programs must have adequate powers, for example, to compel co-operation in the provision of information and records required for evaluation.
- Legal protection must be afforded to all who participate in the process, for example, assessors, notifiers.

- Regulatory bodies should be alert to the role played by systems failures when looking at individuals' performance – and make recommendations for improvement.
- Guidelines or guidance for good medical practice should be issued to guide members of the profession.
- Regulatory bodies should work in partnership with other medical organisations.
- Maintenance of professional competence should be recognised to be an ethical obligation.
- Renewal of registration should be dependent on demonstration of fitness to practise.

Proposals for dissemination and implementation:

Discussion with the members and staff of the Medical Practitioners Board of Victoria, members and staff of other state and territory medical boards and national associations of medical regulatory bodies, and relevant policy officers in the Department of Human Services, Victoria.

PROGRAMMEAPRIL – MAY 2001CANADAVancouver, British ColumbiaCollege of Physicians and Surgeons of British Columbia

Dr Morris VanAndel, Registrar
 Dr Brian Taylor, Deputy Registrar
 Dr Doug Blackman, Deputy Registrar
 Dr Maurine Piercey, Special Deputy Registrar
 Dr Patricia Rebbeck, Deputy Registrar
 Dr Peter Seland, Deputy Registrar

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Dr John Bonn, Registrar
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 Director, Registration & Professional Enhancement, CPSO

The Federation of Medical Licensing Authorities of Canada

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 Dr Denis Laberge, Assistant Director, Practice Enhancement Division
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THE NETHERLANDS

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Vivienne Schelfhout-van Deventer, Lawyer, KNMG, the Royal Dutch Medical Association

SWEDEN

Stockholm

Socialstyrelsen (The National Board of Health & Welfare)

Dr Bo Jordin, Director of Primary Care, Health & Medical Care General Unit
Dr Arne Hallquist & Marie Lawrence, Unit for Medical Quality Development, Division of
Health care & Medical Services

Dr Olof Edharg, formerly Deputy Director-General

The County Councils' & Regions' Mutual Insurance Company

Kaj Essinger, Executive Director

HSAN (The Health & Medical Services Disciplinary Board)

Ulf Eveland, Legal Adviser

Patients' Advisory Committee

Asa Rundquist, Director
Amy Chau

ENGLAND

London

General Medical Council

Finlay Scott, Chief Executive
Mark Paulson, Head of Secretariat
Neil Marshall, Head of Performance
David Skinner, Head of Regulation Policy
Isabel Nisbet, Director, Fitness to Practice
Jane O'Brien, Head of Standards Section
Paul Buckley, Head of Policy
Gordon Lindsay, Policy Adviser
David Morris-Johnson, Communication Manager
Chris Hale, Research & Policy Assistant
Richard Marchant, Registration Section

Matthew Lohn, Solicitor, Field Fisher Waterhouse, Solicitors for the GMC

MAIN BODY

CANADA

Canada is divided into ten provinces and two territories. The regulation of the medical profession occurs on a province or territory basis, similar to the system in Australia. The equivalent to the Australian medical board is the College of Physicians & Surgeons which is established under provincial legislation.

British Columbia

Office Medical Practice Peer Review Program

Background

In the mid 1980's the College of Physicians & Surgeons of British Columbia (CPSBC) became aware of a trend where more and more physicians were electing to discontinue hospital work. The national form of quality assurance and peer review which took place on a daily basis when physicians worked in hospitals was being removed from these physicians.

The College concluded three options were available to determine if physicians were maintaining their competence. These were:

- a documentation of continuing medical education activities (CME) such as done by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada, or
- a form of re-examination or re-certification such as done by the State of New York, or
- a form of performance assessment such as the Office Medical Practice Peer Review Program of the College of Physicians and Surgeons of Ontario (CPSO).

After considering all of the options, the CPSBC elected to develop a program of performance assessment based on the CPSO program which had been in existence since 1981.

The program is designed to assist physicians in providing high quality care to patients. The fundamental purpose of the program is educational and not disciplinary. It is designed to help the physician identify any deficiencies or weaknesses in the office setting and then try to assist the physician in correcting those deficiencies before they become a problem. The program is based on the assumption that an experienced physician can review another physician's office facilities and procedures and medical records and come to a valid determination of the quality of care being provided by that physician. Information obtained in the process of a review cannot be used by any other committee of the CPSBC for any disciplinary purpose.

The Program

Office Medical Practice Peer Review began in 1988. All of the physicians in BC were informed about the program and asked if they would like to volunteer to have an office assessment. From this initial group of volunteers reviewed, the "best" were asked if they would be willing to be assessors. Gradually the pool of assessors grew and the number of physicians being assessed was increased. Based on the results of the CPSO program, CPSBC determined that the physicians who would most likely benefit from the program

were general practitioners or family physicians. The second phase of the program involved a random selection of physicians from this group.

Based on both CPSBC's and CPSO's experience, it became evident to CPSBC that the physician who is most likely to benefit from the program is the physician aged 55 or older. The College therefore started to target those physicians. Subsequently other "at risk" physicians such as those in solo practice or those who have no certification via a hospital have been targeted.

The program is administered by the Committee on Office Medical Practice Assessment. The Committee is comprised of 5 people who have voting rights plus a College Deputy Registrar who acts as Secretary and does not have a right to vote. The members of the Committee are all appointed by the College. None are on the College Council. Two of the members are nominated by the British Columbia Medical Association, one is a GP, and one a specialist.

The doctor selected for review is notified and asked to complete a pre-visit questionnaire. Upon the Committee's receipt of that questionnaire, the doctor is sent a confirmation and a copy of a document entitled "Common Office Observations and Deficiencies" and "Guidelines for Improved Medical Records". This allows the selected physician to start to become familiar with the types of issues that would be addressed during the actual assessment. The doctor is eventually notified of the names of the peer assessor and sent copies of both the "assessors' protocol" and the "assessors' guidelines". The effect of this is to send the physician to be assessed a copy of the "exam" before the visit. Given that the purpose is educational, it is hoped that the physician will in fact read the information and begin to correct some of the obvious deficiencies that they can identify within their own practice.

The review done by the assessor normally takes between three and four hours and consists of consideration of the physical facilities and office procedures and a review of 15 medical records selected randomly of patients seen within the past three months. The assessor meets with the physician at the end of the review for approximately an hour and tries to point out obvious deficiencies and make recommendations as to how the physician might improve. The assessors do not sit in during consultations.

Each assessor prepares an independent report. The reports are then reviewed by the Committee. The physician is then categorised on the following basis:

Category 1 – No significant deficiencies

Category 2 – Minor deficiencies

Category 3 – Deficient records but no deficiency in quality of care

Category 4 – Records so deficient that the quality of care could not be determined

Category 5 – Deficient records and deficient care

Category 6 – Serious risk to patients

All physicians with a Category 3 rating are given specific advice on how to improve their medical records and are then re-visited by a different peer assessor, usually in one year's time. Physicians given a Category 4 rating are invited to attend a Committee meeting, bringing the records reviewed by the initial assessors. The Committee members review the

charts and then conduct a form of "chart stimulated recall" with the physician, trying to determine if the physician is providing an adequate quality of care.

The most common deficiency noted was insufficient medical record documentation to allow an outsider to determine why a patient came to the office, what the physician found out, and what was done about it. Other common problems were lack of referral letters to consultants, inadequate sterilisation of equipment, and lack of an organised emergency kit. The Committee has found that encouraging the physician to develop a patient summary or problem list and a medication list for each patient, and to locate these in a prominent place in the record, has benefited both the regular physician and locum physicians in providing better patient care. The Committee has noted that physicians without deficiencies pay more attention to details. Physicians with deficiencies have often developed habits characterised by inattention to details.

The cost of the program is borne entirely by the CPSBC. The cost consists of an honorarium paid to the assessors, plus their travelling expenses, and the cost of the Committee meetings.

200 office visit assessments are done per year. Half are randomly selected and half are targeted by age alone. All physicians over 55 years old in general practice have now been assessed. The Committee is now looking at specialists, working through the groups of specialists. One assessor is used to assess a general practitioner; two assessors (one specialist and one GP) are used to assess a specialist. Potential assessors are identified by the assessors from the peer groups they are assessing. These potential assessors are then invited to become assessors. The Committee tries to choose assessors from various parts of the Province to minimise their travel but at the same time not have them reviewing their neighbour.

With regard to the training of assessors, all will have been assessed themselves and they are sent out with another assessor initially. There is a manual for assessors. In addition the Committee receives feedback from physicians who are assessed so the Committee learns quickly if there are any problems in relation to an assessor.

Of the GP's, 80% are Category 1 or 2 on first assessment. Of the other 20%, at the second assessment, 80% are meeting the standard - so after the second assessment, 96% are Category 1 or 2.

The Committee plans to have a computer website where the program's philosophy, assessment package and pearls of wisdom regarding common deficiencies with recommendations, will be found.

Self Assessment

Recognising there are approximately 5,000 physicians in BC with an office practice, the Committee considered ways to accelerate the benefits of the program to more physicians than can be reviewed by peers on an annual basis. To this end, the Committee has been providing a self-assessment package to 800 physicians each year. The self-assessment package includes the philosophy and educational mandate of the Committee, as well as the assessment protocol used in the actual peer review. The physician and the office staff are encouraged to perform their own office assessment. The feedback from this initiative continues to be very positive and the Committee has increased the annual distribution to 1,000 physicians. However receiving a self-assessment package does not preclude a doctor from an on-site assessment in the future.

Other Principles

The focus of the program is to try to bring the standards of quality of care up rather than to be punitive. Where the Committee is concerned about the quality of care provided by a physician who after participation in the program has shown no indication of improvement, the Committee refers the physician to the College with a statement of concern (ie, saying that the doctor is beyond the Committee's educational mandate). The College then needs to strike a Committee to look at the doctor.

The College believes that the program works because its purpose is educational and not disciplinary – the conditions of learning are much more conducive in this environment. The attitude of the assessors is positive in that they want to help the physician to be able to help the physician's patients. The College believes that the fact that it is done by peers gives much credibility - these are not inspectors but physicians who were in practice the day before the assessment and will probably be in practice the day after the assessment. They bring a great deal of practicality to the process.

The College states that the fact that the process is done in the doctor's own milieu, looking at the doctor's own office facilities and own medical records about his/her own patients, makes it much more relevant. As a result of the process, specific, targeted, focussed issues regarding the physician are brought to the physician's attention and specific advice is given on how to improve. The College concludes that physicians do improve performance when they are given specific information identifying deficiencies and advice on how to correct them. The College states that the physicians assessed are positive about the program. The College is satisfied that the money spent on the program has been well spent and that the College is improving physicians' performance as a consequence.

Legislative framework

The CPSBC has as some of its objects:

- to superintend the practice of the profession;
- to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst members;
- to establish and maintain a continuing competence program to promote high practice standards amongst members. (Section 3(2), paras (a), (d) and (e) *Medical Practitioners Act* [RSC 1996] Chapter 285 ("the Act")).

The powers of the Council of the CPSBC include that it may make rules:

- (f) establishing the records and accounts to be kept by members of the College in their practice of medicine;
- (n) respecting the investigation or evaluation of members of the College under section 51, 53, 63 or 64, and requiring and providing for the audit, inspection, copying, removal or preservation of records kept by members with respect to their medical practices (section 5).

The Council has the authority to appoint Committees or Boards and delegate powers to them as it sees fit (section 26).

The Council or the Executive Committee may, for the purpose of sampling or monitoring the standards of practice of members and assisting members in their practice, require a

member to allow evaluation of the member's professional performance and inspection of the member's clinical records by one or more medical practitioners designated by the Council or Executive Committee (section 51(6)).

Legal protection is provided to members of Committees of the College and persons who provide a service under the direction of a member or officer of the College to a Committee for anything done or omitted in good faith.

Each person employed in the administration of sections 51 - 66 must preserve confidentiality with respect to all matters or things that come to the person's knowledge or into the person's possession in the course of their duties except as may be required in connection with the administration of sections 51 - 66 and any rules relating to those sections, or as may be authorised by the Executive Committee if it considers disclosure to be in the public interest (section 70).

Section 70 also provides that a person employed in the administration of sections 51 to 66 must not give or be compelled to give evidence in a court or in proceedings of a judicial nature concerning knowledge gained in the exercise of a power or duty under those and other sections except in a proceeding under the Act or the Rules.

The Committee on Office Medical Practice Assessment is established under Part XIII of the Rules made under the Act. Part XIII comprises Rules 88 - 97.

The purpose of the Committee is stated to be "to establish, develop and administer an ongoing program of peer assessment of the office practice of members of the college in the member's chosen field to the end that the public may be served by helping members of the college to maintain proper standards of practice in the care of patients and the keeping of records". (Rule 89).

Rules 90 – 97 define the composition of the Committee, terms of office of its members, manner of conducting its business, reporting obligations and manner of selection of members of the College to be assessed. The Rules also provide that every member of the College whose standards of practice are the subject of an assessment shall co-operate fully with the Committee and with its assessors. The co-operation required is set out in Rule 94 and includes, for example, permitting assessors appointed by the Committee to enter and inspect the premises where he/she engages in the practice of medicine, permitting assessors to inspect the member's records of the care of patients, and providing to the Committee or its assessors information requested by them in respect of the care of patients or the member's records of the care of patients.

The Rules also provide that information learned in the course of a peer assessment program will not be used against a member in any disciplinary proceedings unless it is for knowingly giving false information, failure after due notice by the Committee to comply with the Act, the Rules, the Code of Ethics or a resolution of the Council, or conduct which constitutes a serious perceived risk to the public or constitutes a serious breach of ethics.

Ontario

The College of Physicians and Surgeons of Ontario (CPSO) established the Peer Assessment Program in 1980, a program designed to assist the College to ensure the quality of the practice of the medical profession and the continuing competence of members of the profession.

Each year the College initiates assessments of physicians in general/family practice and several speciality areas (eg psychiatry, paediatrics, obstetrics, and gynaecology, internal medicine). All physicians who turn 70 years of age in a given year are automatically selected for assessment, and the program conducts assessments on a random selection of physicians within specific practice and specialty areas. In addition, a physician may have been referred to the program from another area of the College, for example Complaints.

Each selected physician is sent a pre-visit questionnaire, which provides the peer assessment committee with information on demographic status, education and training experience, and practice characteristics (for example, number of hours worked in a typical week, number of patients seen in a typical week, practice restrictions or areas of interest). On the basis of the information provided, the physician can be considered exempt from assessment if he or she, for example, has been assessed by the CPSO within the past ten years, has been in practice for less than five years, or does not have an office practice.

After accounting for exemptions, the program arranges for an assessor to visit a physician in his or her practice at a mutually agreed time. Each assessment typically takes half a day and consists of three parts:

1. Review of the physical office facilities (for example, emergency equipment available, staff on site, waste disposal, sterilisation procedures);
2. Review of the record-keeping system and the content of approximately 20 – 30 medical records, to evaluate the physician's compliance with the legal requirements for medical records and the CPSO's expectations for quality record-keeping practices and to indicate the quality of the physician's examinations, history-taking, diagnosis, and management plan (for example, treatment, prescribing); and
3. The quality of care provided, as determined by the medical record content and the discussions between the physician and the assessor.

The assessor completes an Assessment Report Form based on explicit criteria, 31 of which concern medical records (for example, "When medications are prescribed are dose and duration recorded?") and 13 of which address the quality of care provided by the physician (for example, "Is the medication prescribed appropriate to the condition being treated?"). The assessor is asked to choose from the following categories to evaluate the medical records reviewed:

- always
- usually (more than 50% of the time)
- sometimes (between 0% - 50% of the time)
- never

The final part of the assessment encompasses a discussion in which the assessor provides the findings to the physician and seeks clarification on any aspects of the medical records and/or the physician's medical knowledge.

Decisions regarding the quality of each physician's practice are the responsibility of the Quality Assurance Committee (QAC) and not of the assessor. QAC meets monthly and is accountable to the CPSO's Governing Council. For each of the physicians assessed, the Committee considers the pre-visit questionnaire and the assessment report form, which includes explicit and structured questions as well as a narrative report from the assessor on the interview and examples cited by the assessor from the charts that were reviewed. The Committee assigns to the physician's practice a grade that reflects the quality of care and calibre of the records.

The grading system is as follows:

- Grade B1: a physician's assessment report must essentially be perfect, with no examples where care is in doubt.
- Grade B2: the report reveals minor deficiencies in record keeping or care.
- Grade C1: there are more errors in charting but still only minor concerns about care.
- Grade C2: records are so deficient that a judgement about care cannot be made.
- Grade D: there is evidence of inappropriate care.

The physicians who are most in need of help, ie those who receive either a D or C2, are requested to meet with the Quality Assurance Committee to discuss the findings. All physicians are provided with a copy of the assessment report ahead of time and are requested to bring all the charts cited by the assessor and up to 12 other charts of their own choice.

65 – 70% of physicians are doing quite well. In those instances, the report is sent to the doctor with some positive feedback from the assessor and the QAC and some suggestions for improvement. No further action is taken.

20% fall within the "record keeping deficiency" area. The deficiencies in record keeping are not indicating poor quality of care. These physicians are given 6-12 months to improve and then are assessed again. The reassessment may be an on-site visit by another assessor or it may consist of the physician sending copies of medical records, specified by the Committee, for further evaluation.

10% will be invited to see the Committee because it has some concerns. Some physicians will keep records that make it difficult to tell whether patients are receiving quality medical care, and some physicians are identified as having specific clinical deficiencies. Some may go no further after clarification. In approximately 2-4% of all random and age-related peer assessments conducted, a physician will be required to undergo a comprehensive assessment which evaluates medical knowledge, skill, judgement and clinical knowledge (PREP or SAP – see below).

Assessors

Each assessor is a physician who practises in the same area of medicine as the physician undergoing assessment and who has been previously assessed by the CPSO and found to have an exemplary practice. In the early years of the program, two assessors visited each practice and conducted independent reviews. However, it was later shown that use of a single assessor yielded comparable reliability.

Ongoing training for assessors consists of an annual seminar, video and audio tapes with scenarios and frequently asked questions (for home use), extensive written material including a bulletin issued every six to eight months, and feedback concerning their completed assessments. The College is trying to set up Internet access for assessors so that they can communicate with each other.

Potential assessors can be recommended by other assessors. If they haven't yet been assessed, they are assessed before becoming assessors. There are 180 physicians

working as assessors and all are currently practising. The College works to have a lot of contact with assessors through the process.

The College has been attentive to the geographic spread of assessors. The current spread is not bad though it is very hard to get assessors in Northern Ontario and outside Toronto. This situation is getting better. The College is currently brainstorming with assessors about how the College can use the expertise of the assessors as mentors in local communities, ie as physicians to whom other physicians can look for advice etc.

Quality Assurance Committee

The Quality Assurance Committee is comprised of 14 people and currently works in panels of 3-5 people. Their process is as follows:

The Committee will have the assessment report and will say to the physician that it wants to talk about several points. The Committee will look at particular records to see if the assessor's view is an accurate reflection of the record keeping. The Committee may need to look at more records to see if the particular records are an accurate reflection of the total picture. The Committee tries not to be confrontational – eg, if a Committee member is questioning the physician about his/her records, the Committee member will sit next to them. The Committee then decides what it will do.

The best case outcome is that no problems are identified but some suggestions are made for improvement. The worst case outcome is that the physician is required to go through more comprehensive assessment. The physician may have knowledge but may not be applying it. No physician will lose their licence at the end of the meeting but the Committee may have concerns which lead to the physician being referred to the Physician Review and Enhancement Program (PREP) or the Specialists' Assessment Program (SAP). PREP is a one day College program for family physicians operated by McMaster University. SAP involves observation of a specialist in their place of work for up to three days. A report will be sent back to the QAC.

Peer assessment is paid for by the College out of its general operating funds. An amount of money is approved by the College Council for assessment each year. The Committee then decides how to allocate the funds. An assessment costs \$1,100. In relation to PREP and SAP, a physician must pay \$3,700 towards the cost. PREP costs \$6,000 per physician so the College pays \$2,300. The cost of SAP is unknown – the main cost is in the assessor's time. In general the profession seems to accept the cost of peer assessment but of course some individuals complain about the PREP and SAP cost.

Remedial training programs

Most remedial training programs are external to the College. An appropriate course will of course depend on an individual physician's needs. The College does have some courses – they are revenue generating and were developed to fill a need which was not being met elsewhere. The courses are:

1. Record keeping
2. Communication skills
3. Prescribing skills especially narcotics
4. Boundary keeping.

Physicians are told what they need remediation in and informed of the College course. However they can attend other courses where that suits them. The College can provide guidance on all options on offer.

Summary

The program is educative rather than a "bad apple" approach. The program focuses on strengths and weaknesses, identifying where the physician might improve.

The College has tried to set up a program that is not inflammatory. Most physicians cooperate. The program operates on a partnership model, with the College working continually with professional associations and CME departments of universities.

Studies have shown that peer assessment program interventions can help physicians make sustained practice improvements in their medical records and the quality of patient care. (see Norton P G, Dunn E V, Beckett R, Faulkner D. 'Long-Term Follow-up in the Peer Assessment Program for Nonspecialist Physicians in Ontario, Canada.' *Jt Comm J Qual Improv* 24:334-341, 1998.)

There are a number of protections for the doctor - eg the Peer Assessment Program cannot share information with other Committees of the College. This becomes a problem if the physician doesn't respond to the program but it is believed the profession accepts the program better with this protection in place. The Quality Assurance Committee can refer the physician to other College Committees (but because information can't be provided, the other Committee may have difficulty in deciding where to start and their investigations may generate a different outcome). QAC can impose limitations on a physician. If a physician's problems are beyond the QAC's mandate, the physician is referred to the College Council.

There is no relationship between the Peer Assessment Program and renewal of registration, though the College's future plans might include some type of re-certification in order for a physician to be licensed. The goal of the College is to work towards the full implementation of the 3 step MEPP Program (see pp 22 – 24 below).

Legislative framework

The legislative framework for the regulation of the medical profession in Ontario comprises the *Regulated Health Professions Act 1991* (RHPA), the Health Professions Procedural Code which is Schedule 2 to the RHPA, the *Medicine Act 1991*, and Regulations made under the *Medicine Act*. A Peer Assessment and Education Regulation has been made pursuant to the power to make regulations prescribing a quality assurance program.

The RHPA overrides provisions in other Acts such as provisions dealing with confidentiality of records. Legal protection is provided to assessors by section 38 of the RHPA which provides an immunity from civil proceedings for acts done in good faith in the performance of a duty or exercise of a power under the Act or other relevant Acts or Regulations.

Québec

The medical profession in Québec is regulated by the Collège des médecins du Québec. The College is established under the *Medical Act*.

The *Professional Code* is a piece of umbrella legislation that applies to all officially recognised professions (of which medicine is one). The *Code* clearly states that the main function of each order (or profession) is to protect the public. To this end, it must supervise the practice of the profession by its members.

Structure

The College has three divisions, one of which is the Practice Enhancement Division (PED). The mandate of the PED is to oversee the practice of physicians and to enhance that practice, with a view to protecting the public and helping to improve the health of Quebecers. To fulfil its mandate the Practice Enhancement Division performs the following functions:

- supports the Professional Inspection Committee and Continuing Medical Education Committee;
- assesses the quality of practice of physicians in private practice and in institutions through monitoring and evaluation at three levels, among other means;
- assesses the quality of medical practice in institutions, notably by promoting quality management;
- intervenes with a view to improving the competence of physicians in private practice as well as in institutions;
- develop guidelines and practice guides.

Professional Inspection Committee

The Professional Inspection Committee (PIC) consists of eight members appointed by the Board of the College and chosen from among the members of the College. Six members are practising, including a GP, an internist, a gynaecologist and obstetrician, a surgeon, and a psychiatrist. The term of office of each member is one year which is renewable, and members usually serve for three years.

The mandate of the PIC is to determine a program for the supervision of the practice of the profession. The Committee's functions are:

- inspection of records, books, registers, medications, poisons, products, substances, apparatus and equipment related to a physician's practice;
- enquiries into the professional competence of a physician;
- enquiries into the quality of the medical care provided in establishments.

The PIC thus runs programs for physicians acting on an individual basis, establishments and institutions. There are seven or eight programs running at any one time. An example of a program is to visit every three years each physician who has been practising for 35 years or more. These physicians are identified from statistics from the College or the paying agency of Québec. Other programs include: those who are billing outside their area of practice; all GP's for whom psychotherapy billing comprises more than 40% of their practice; prescription profiles; GP's consultations to more than 80% of their patients; physicians who change their field of practice; general surgeons who deliver bills for more than 80% of services in their office (ie not operating); GP's who bill more than 60% for house calls.

The following activities are investigated during inspection visits: general activities, eg hours of practice, mean number of house calls, hours in institutions, hours on house calls, site where investigation held, conform to regulations of the College, eg on facilities, record

keeping etc, maintenance of competence activities. The investigator gives a score of 1-5; the passing mark is 3. When the investigator is back in the office after visiting the doctor, he/she completes a form, giving scores.

The investigator then looks at record keeping. The College has published three guides to record keeping, according to where the physician is practising, ie in private practice and in CLSC's, in a hospital centre and in residential and long-term care centres (RLTCC's).

The investigator makes a judgement on the quality of care based on:

- investigation – clinical and para-clinical;
- diagnosis;
- quality of treatment.

The investigator's report is sent to the PIC.

There are eight investigators, all full time. The College's total budget is \$7.5 - \$8 million pa. The budget of the PED is \$2.5 pa.

All physicians and institutions must co-operate in professional inspection visits by supplying the information and records required for group and individual evaluations.

The investigator makes a recommendation in his/her report. When the findings from professional inspection visits justify it, the Committee may make recommendations to the physician or institution visited. In certain specific cases, the Committee may recommend that the Executive Committee impose a refresher training course with or without right to practice (ie with or without limitations).

The PIC can also inform the Inquiries Division of the College of derogation of rules, regulations, *code of ethics* of the College (the function of the Inquiries Division is to conduct inquiries into complaints or information to the effect that a physician may have committed an offence under the provisions of the *Professional Code* or *Medical Act* or the Regulations ensuing from these laws, particularly the *Code of ethics of physicians*).

The PIC has a bank of 100 physicians acting as experts for it. Experts are chosen from an inspection already done in a hospital, ie a good practitioner. A meeting is held each year with investigators and experts to discuss methodology, how the process is going etc. Experts are asked to do approximately two reports a year. They are paid, but not much – ie \$500 per day plus expenses.

The objective of a professional inspection visit in institutions could include:

- to assess the quality of medical practice of members;
- check that regulations in force in institutions comply with the regulations of the College and the *Act respecting health services and social services*.

The organisation is looked at, and then the different clinical departments are examined. An assessment is done of the quality of chart keeping and the quality of care provided within the hospital.

The College is now moving to another way of assessing quality of care in practice, which is by means of clinical indicators. When a hospital performs above or below the mean, the Committee undertakes an investigation with an expert. This is a less expensive way to assess quality of care.

The Committee is continually reviewing and changing its process, trying to improve it. The Committee started operation in 1974, inspecting just public facilities, mostly hospitals. In 1983 individual assessment of competence started. The Committee is currently performing 30 investigations in public institutions per year and 150 investigations of individuals per year. The Committee is also running five programs a year on clinical indicators – this commenced two years ago. The trend is to increase these programs. The Committee is looking at physicians who are performing less than 25 deliveries of babies per year. The Committee has written to these physicians informing them that the College believes that to maintain competence a physician needs to be delivering more than 25 babies a year, seeking their comment and asking how they have maintained their competence during that period. Some investigation will be done.

Another method used by the College to assess quality and competence of physicians, especially GP's, is to call them to the College and have them interviewed by two assessors (peers) who are trained to assess them. The physician being assessed will be given a sample of 20 different clinical situations. The physician is requested to tell the assessors what his/her diagnosis is and how he/she would treat the patient. The assessors put the physician right if he/she has not made the right diagnosis and then the physician proceeds, being corrected if necessary. This method is used especially if the physician's chart keeping is so bad that the investigator can't assess quality of care. This method can test the knowledge of physicians and ability to apply that knowledge. The College has been using the method for 12-15 years and assesses 5-10 physicians a year. The method is limited to GP's. The College is trying to develop such a tool for specialists but it has not been completed.

The College has found that there is quite a good correlation between chart keeping and an investigator's feeling about a doctor. However, chart review doesn't assess all the aspects of the practice of medicine – eg relationship with patients. The College is thinking about trying to do some enquiry of patients, eg requesting 10-15 patients to complete a questionnaire. However the feeling is that the profession is not quite open to this yet.

Remediation

When doing their investigations, investigators make recommendations regarding what the physician can do to improve the quality of care. If it's a knowledge problem the physician is referred for the construction of a remedial program which may involve, for example, the reading of certain papers and preparation of a resume for the program director. In other cases, a kind of tutorship is arranged whereby the physician will meet with a peer and discuss some of his/her charts for 2-3 hours. Meetings will take place for 3 hours every second week for at least 3-4 months. Tutorship is a very good tool for older physicians, assisting them to change their habits.

In some other instances, a physician's knowledge is so poor that something else is needed. A training program is therefore imposed. Both a tutorship and a training program will have a list of the objectives sought to be obtained. A total of 10-15 tutorships and training courses are conducted each year. 5-6 a year are done full time for 3-6 months. The physician has to pay \$100 a day. Part time training courses involve 2-3 days a week and last 3-6 months. Tutorships can continue on past their nominated end because the physician finds it so useful.

Continuing Medical Education Committee

The mandate of the Continuing Medical Education Committee is to help maintain and improve the competence of physicians, so that they provide the best possible quality of care and collaborate in the promotion of health.

With respect to continuing education, the Continuing Medical Education Committee and the Practice Enhancement Division intervene mainly in four areas of activity:

- evaluation and refresher training activities;
- workshops on the physician-patient relationship, the periodic medical check up, record keeping, and communication on breast cancer;
- the secretariat of the Québec Board of Continuing Medical Education;
- research and development.

Each and every physician is responsible for maintaining his or her professional competence. This is a fundamental, ethical obligation. Thus educational activities may only be imposed on a physician in certain circumstances, notably those described in the *Regulation respecting periods of refresher training and refresher courses that may be imposed on physicians*. The College therefore strives to promote access to quality educational activities for groups or individuals. All physicians may consult the Continuing Medical Education Committee on any competence-related question.

Remedial Programs

An Assistant Director of the Practice Enhancement Division is responsible for putting together remedial programs for physicians. The programs are also for enhancement CME, not just for quality deficiency - eg if a practitioner has been away from practice for more than 4 years, he/she needs to prove competency for practice. To assist them to do so, they will call the College and ask for a training program. Other examples are doctors who are looking to change their area of practice, ie re-orientation, and some who want specific skills/knowledge, eg in endocrinology. Practitioners are also referred from other committees within the College such as the Administration Committee, Discipline Committee, Practice Enhancement Committee, for real remedial CME.

The Assistant Director meets the physician to be sure of the objective. He will sometimes have received information from the Committee which referred the practitioner, which is of assistance. The length and type of the activity will be decided – sometimes it will be a tutorial, sometimes training, sometimes a course. The activity selected will depend on the extent of the weaknesses. If the weaknesses are many, a training course will be chosen. 80% of the trainers engaged are Course Directors at universities.

The Assistant Director receives 50 – 100 referrals per year to plan CME intervention. Usually the physician pays and the College pays for the report at completion.

The Assistant Director has a meeting with the physician and the trainer to be sure they understand the College's expectations. They will negotiate modality – eg full time, part time, some courses to attend, observe trainer in practice, observe trainee in practice.

The length of a course depends on the width of the training program and objectives etc. A course may take only one day or may be seven to nine months full time. An example of the latter is one for a female physician who has been out of practice for some years raising a family – it may take in excess of six months full time to bring her up to date.

The program director from university residency programs is usually the trainer. There are four universities from which to choose. It is quite easy to find a program director, particularly if the training is for enhancement. If the training is for remediation and the problem is very small, it is also quite easy. But if the trainee's problem is total competency failure and he/she doesn't have insight, is not willing and is aged, it is more difficult to find a trainer. If the trainee is well known in his/her community it will be difficult to find a trainer.

Likewise there is only one English speaking university to provide trainers for English speaking physicians.

There is no basic fee for a course – in fact it may be free because it is already being done for others. Costs otherwise range from \$100 per day to approximately \$500 per day. The physician receives no income while he/she is not practising. If a physician's weakness is very small they could just sit in a post-graduate training course. Physicians can find courses themselves or go to a conference or particular lecture recommended by the College.

Tutorship is always performed by a peer, eg a specialist of the physician's own specialty. The physician being tutored brings their own charts to a peer and receives information and teaching exposure. The teaching is one to one and may be half a day for a week or two weeks – eg high blood pressure this week, next week diabetes, two weeks later low back pain, headaches. The objectives of the tutorial are followed. Tutors are usually teachers in the universities. In Montreal all the teachers still have an office practice so it is appropriate to use them. For family doctors it is sometimes easy to find a tutor in practice, eg a young female who has time to spend because she has reduced her practice to raise children. The Assistant Director always checks to see if the proposed tutor is a good physician, by talking to the program director if the physician is teaching. If the physician is not teaching, the Assistant Director checks the College file to see if the proposed tutor is known to the College and, if he/she has been assessed, how they performed in the assessment.

At the end of the training program or tutorial, the trainer must complete a report. The expectation is not that the question asked is "Is this physician able to pass the Licensing Board Examination?" Instead the question is "Is the physician minimally competent to do his job, is he safe for the public, is he in the mean of competency for his/her field of practice?" (eg, are his skills good for a surgeon to do surgery without higher morbidity or complications than the mean). The report is then considered by the Administrative Committee. One or two physicians a year are struck off the roll. If the Assistant Director realises before the training program that the physician's cognitive ability is insufficient for him/her to learn, the Assistant Director convinces him/her to retire. Usually the physician accepts this if he or she is aged more than 55 years.

If the physician needs more training after the course has been completed, for example another couple of months, this will occur. The trainer's report may say that the physician is safe but needs more training. The Administrative Committee will allow the physician to return to practice and do another 2-3 months part time training.

Until 1997 there was no relation between the College's monitoring activities and CME – ie they operated as two separate departments. In 1997, the Professional Inspection Department was merged with the Continuing Medical Education Department to form the Practice Enhancement Division. Since 1997, and after MEPP, there has been an integrated approach of the surveillance activities and the proposed interventions. There has also been development of performance indicators in many areas of practice, and application of the monitoring and enhancement model to the establishments.

Monitoring and Enhancement of Physician Performance (MEPP)

In 1993 the Federation of Medical Licensing Authorities of Canada (FMLAC) launched a project which addressed the issue of ensuring that physicians in practice maintain an appropriate level of performance for the duration of their professional lives. Through a series of workshops and educational sessions, consensus was reached on:

1. the four major areas of physician performance;
2. a model for monitoring and enhancing physician performance; and
3. a three step system for the monitoring and enhancement of all physicians that would address the four areas of physician performance.

Common performance problems known to occur in physicians were identified and classified into four categories: deficient competence, inappropriate behaviour, physician impairment, inappropriate use of resources. These were used to define four major areas of physician performance.

Following identification of these four areas, FMLAC and its member licensing authorities developed a Canadian Model to monitor and enhance the performance of all physicians. While taking a leadership role, licensing authorities will work closely with other medical organisations (such as the Association of Canadian Medical Colleges, Medical Council of Canada, Royal College of Physicians & Surgeons of Canada) in the prevention, assessment and remediation of the performance problems identified in practising physicians.

The Three Step System

Step One

All physicians will be screened. The screening tools at this step must be easy to use, inexpensive, valid, reliable and acceptable to the profession. Tools to be considered include: existing databases (patient-encounter data, physician demographics, prescribing profiles, CME profiles etc), patient questionnaires and peer questionnaires.

Step Two

FMLAC estimates that 10% - 20% of physicians screened in Step One will be found to have practice profiles that suggest a risk or a need. An attempt will be made to determine whether the problem is localised to an individual physician or is more systemic. Physicians found to be at risk will have a structured interview by a peer, and their office or hospital practice will be reviewed in more detail.

Step Three

FMLAC estimates that 1% - 2% of the physicians originally screened will require a detailed and individualised needs assessment to determine the cause of the performance problem and whether it can be resolved through educational techniques. Such an assessment might involve multiple-choice questions to evaluate knowledge, standardised patients to evaluate clinical skills and attitudes, patient management problems to evaluate judgement, and chart-stimulated recall to evaluate the appropriateness of care.

Other Principles

Feedback to individual physicians is essential if the monitoring system is to be successful and acceptable to the profession. The feedback allows physicians to identify adequate and inadequate areas of practice performance. Furthermore, there must be mechanisms throughout the monitoring system for communicating with each physician frequently and systemically.

Enhancement programs addressing the four areas of performance need to be identified or developed along with the monitoring system. These programs address the individual needs of physicians and will be made available in different places across Canada. The programs will characteristically include: use of adult education principles and educational contracts; a peer-to-peer approach; a one-to-one traineeship or mentorship approach; monitoring of progress made by the physician; a willingness of peers to participate; educational support from national medical associations; and appropriate financial and organisational support.

FMLAC is strongly committed to the development and implementation of MEPP. Various Provinces have begun developing programs at one or more of the three steps of the model. The goal is that all physicians practising in Canada will have their clinical performance monitored, will receive feedback and will be offered enhancement activities that will allow them to maintain acceptable standards of practice. (Lescop J, Kaigas T, Waymouth V. *'The Canadian model for monitoring and enhancing physicians' performance'* presented by Dr Lescop at Australian and New Zealand Medical Boards and Councils Seminar "Fit to Practise", Melbourne, 19 & 20 November 1999).

SWEDEN

Sweden has a population of 8.9 million inhabitants. The governing process in Sweden works at three democratically elected levels: the Swedish Parliament at national level, County Councils at regional level and the Municipalities at local level, each having different spheres of responsibility.

There are 289 Municipalities (local authorities) which are responsible for issues in the people's immediate environment. The 21 County Councils are responsible for carrying out tasks that are common to the region which would otherwise drain the financial resources of a local authority. Their main function is to assume responsibility for all health and medical care in each County and planning the dental care system. County Councils are also responsible for various forms of education, the environment, cultural matters and for public transport in the County.

The practical implementation of parliamentary and government decisions is entrusted to authorities and central administrative boards which are relatively independent and able to take decisions on their own responsibility, although in accordance with parliamentary decisions and government guidelines.

The National Board of Health and Welfare ("the Board") is one of several Boards under the Ministry of Health and Social Affairs. The Board is divided into two divisions – medical care and social services. The Board's overall aim is to promote:

- good health and social welfare; and
- high quality care on equal terms for the entire population.

The Board is a national expert and supervisory authority for:

- social services;
- health care and medical services;
- dental care;

- support and service to the disabled;
- health protection;
- infectious diseases prevention.

The main tasks of the Board are:

- supervision of medical care and social services as to quality, safety and the rights of the individual;
- evaluation and follow-up studies of social policy;
- mediation of expertise (publish recommendations on how to treat – ie guidelines);
- development and training;
- coordination of social services statistics;
- epidemiological surveying.

The Board works by order of the government and on its own initiative, and in co-operation with other agencies and organisations. Its primary target groups are authorities, decision makers, organisers, providers and professionals. Its work is focused on the population and patients/clients, with special attention to disadvantaged groups.

The national government is responsible for legislation, supervision, monitoring and evaluation (through the Board), the issuing of guidelines, and funding (approximately 20% is spent on health care).

80% of the funding of health care occurs at the regional and local level, from local taxes. The Counties are also responsible for the provision of health care. In the past, the care was provided directly by the Counties but in the last decade the system has been opened up and the County may now sub-contract the services. This has promoted progress with the introduction of a provider purchasing system. Different Counties have chosen different roads – some are very ambitious to keep the services within their own organisation, resulting in little privatisation. Others are very eager to open up to private services. There is not yet sufficient data to say that one or the other (County/private is better). Private services are mostly in primary health care – there is only one private hospital in Sweden.

Public health care is provided through regional hospitals (9 in number), County hospitals (80 in number) and Primary Health Care Centres (1,000 in number). Private health care is provided through private enterprising (with public funding) ie family doctors, private practitioners/physiotherapists, private practising dentists, and others. There are also private nursing homes. Patient fees come out of patients' pockets. Health care has never been free of charge – it was always felt that individuals should be aware of their responsibilities and therefore pay a little bit towards the care. That "little bit" has become a little more in recent years.

The 289 municipalities provide housing and long time care for the elderly and disabled, some primary care (in five municipalities), and nurse practitioners.

Health care is financed as follows:

- County Councils (covered by taxes) 77%
- Government (covered by taxes) 9%
- Patient fees (co-payment) 4%
- Other sources 10%

A very important role of the Board is the provision of support for quality improvement in the provision of health care. The goal which is sought to be reached is a common definition of good care, and then the provision of this high quality care to the entire population, independent of where a person lives or who he/she is. This goal is sought to be achieved through the Unit for Medical Quality Development which has as its main task to change medical practice by the use of information and provision of current knowledge.

The Board's main target groups are health care staff, politicians and administrators. The Board creates and spreads knowledge about the health care system – the first tool. Patient information is gathered together to form a "State of the Art" in areas such as cardiology, internal medicine, urology, paediatrics, orthopaedics, surgery, gynaecology and obstetrics, and ophthalmology. State of the Art is a synthesis of current knowledge in the particular field based on scientific data. Approximately 40 State of the Art documents have been produced with approximately 20 more to be released in 2001. The same formula is followed for each document and it is published on the website so it can be updated.

The second tool is national guidelines. The purpose of the guidelines is to enhance patients' opportunities for receiving equitable, evidence-based care throughout the country, ie to try to make the provision of health care more equal for everyone. The national guidelines are based on knowledge and expertise that has already been developed. National guidelines are followed up with regional protocols which are the most important part of the process. The development of regional and local protocols shall be based on the national guidelines and used as a basis for establishing individual care agreements between the individual patient and the care provider.

It takes up to two years for the Board to develop a national guideline, and it then needs to be revised every two years. The following bodies are consulted in the development of national guidelines: patients and relatives, representatives of the medical profession, associations of local authorities, the National Board of Health and Welfare, and the Federation of Swedish County Councils. The Board works very closely with patients and relatives as a reference group. Three versions of a guideline are produced, one for each of: health care staff; patients; governing bodies. Examples of national guidelines are those relating to diabetes, coronary artery services, and stroke. The following will be produced soon: rheumatoid arthritis, psychoses (mainly schizophrenia), near-suicide patients, hip fracture, cancer, asthma/COL.

Implementation of national guidelines occurs in the working process (through a work group and a reference group), by being referred for consideration to all county councils, concerned professional and patient organisations, and through regional meetings. They assist in prioritisation in health care.

The third element used in pursuit of the goal is Follow-up. Follow-up is achieved through National Health Care Registers, National Health Care Quality Registers, and studies of current practice.

The Centre for Epidemiology at the Board has a national responsibility for several national registers. Examples of these are as follows:

- The Hospital Discharge Register, started in 1964;
- The Cancer Register, started in 1958;
- The Medical Birth Register, started in 1973;
- The Cancer-Environment Register, started in 1978.

The Code of Status issued in 1996 requires that all health and medical services shall maintain systems for planning, implementing, evaluating and improving the quality of services. It also provides that all staff shall participate in the continuous, systematic improvement of quality of services.

National Health Care Quality Registers

Annually since 1990 the Swedish Government and the County Councils have allocated resources for supporting the development and operation of National Health Care Quality Registers (NHCQR). Fifty NHCQR's are or will eventually become national in scope. All were started by the medical profession, are participated in on a voluntary basis, and support efforts to improve the quality of clinical work. The aim of the NHCQR's is to provide knowledge of outcome and results to participating units over time and compared to the national average, to provide a base for evaluation and improvement of the medical quality, and dissemination of good medical practice. The Registers can be used for planning, follow up, evaluation, quality assurance, research and producing statistics.

To succeed a Register needs to have: professional support and confidence; national unity on which measurements to use; an easy way of reporting; regular and quick feedback; a feeling that the data is useful; enthusiasm and patience.

The Registers are not designed as tools for supervision, nor are they used for that purpose. They are all initiated by representatives of the medical profession and constructed to support quality improvement at their own departments. A hospital is a host for a Register. Each register must publish annual outcome analysis reports.

The Quality Register process involves: the building up of a Register (general acceptance/confidence, consensus on contents, feedback routines, find units to come along); identifying differences (diagnostic procedure, indications, treatment, medical results, patient experience); discussion and analysis (projects, benchmarking, building network); changed behaviour (information, training, guidelines, local and regional continuous improvement work); resulting in the outcome of fewer complications and lower mortality.

An example of a Register is the National Stroke Register which started in 1993 and has a coverage of 80%. Its purpose is to support a high and consistent quality of care for stroke patients throughout Sweden. The Register contains few, but important, indicators of diagnosis, care, outcomes and prognosis. Findings of the register include that there are large geographical differences in: % treated at stroke unit, % examined with CT, and % unspecified stroke diagnosis. After five years, the Register can show a positive development in all these areas.

In summary, the Board conceives of knowledge, guidelines and follow-up as being three points on a circle, one leading to the next, ie knowledge → guidelines → follow up → knowledge. A simple summary is:

1. Doing what you do
2. Knowing what you do
3. Knowing what you should do
4. Doing what you should do

"Lex Maria" Cases

Lex Maria is the name of legislation enacted in 1937 which obliges health care providers to report serious injuries and risks to the National Board of Health and Welfare. There is a managing doctor or nurse in each hospital who is responsible for Lex Maria cases and makes the judgement whether the incident should be reported to the Board or not. If the case is reported, the Board sometimes visits the hospital and examines the documentation of the incident to investigate what has happened and which preventive steps have been implemented. (Nordlund Y G and Edgren L. 'Patient Complaint Systems in Health Care – A Comparative Study between the Netherlands and Sweden.' *European Journal of Health Law* No. 6: 133-154, 1999 at 146-7).

Disciplinary Action

If a malpractice question is raised, a report is made to the Medical Disciplinary Board (HSAN, The Health and Medical Services Disciplinary Board). The report could be made by the patient or someone close to the patient (ie close next of kin), or by the National Board of Health and Welfare (eg if the Board hears of prescription habits of concern, it will investigate of its own motion and refer the matter to the Disciplinary Board). 2,500 reports are made to the Disciplinary Board annually but less than 10% end in disciplinary action. Sanctions available are reprimand, warnings, and withdrawal of licence. However, identifying the problem is the focus. The Disciplinary Board will inform the National Board if it receives a complaint that the National Board should know about. The National Board can be informed at any time – however this doesn't happen often.

Written decisions of the Disciplinary Board are sent to the patient, doctor and National Board, and to the hospital or other institution where the doctor works. The Chief of the hospital receives a copy of the complaint and the request for medical records is also sent to the Chief of the hospital during the investigation of the complaint, so the Chief knows what is going on.

The role of the Disciplinary Board is not to punish but to improve the quality of care. The Board's decisions are intended to result in lessons being learnt. The decisions are published in the Swedish Medical Journal, but without identifying the doctor. Newspapers, especially in the country, are very interested in the cases.

Patient Insurance

In Sweden the issue of how patients who have been injured in connection with medical treatment shall be compensated has been discussed for a long time (Espersson C. *The Swedish Patient Insurance – A pragmatic solution*. The Swedish Patient Insurance Association, 2000). Even after a new tort law came into effect in 1972 it was difficult for patients to prove, in the context of a court proceeding, that an injury resulted from an error or omission by hospital staff, in connection with treatment. A reason for this is that circumstances in health care are often complicated and difficult to investigate by those

without special expertise. It can therefore be a long and costly process for the patient to obtain compensation through tort law (ibid at 3).

On 1 January 1975 the Federation of Swedish County Councils established a voluntary patient insurance scheme which was administered by an insurance consortium. By means of this insurance scheme, public and private care providers voluntarily assumed the responsibility for compensating treatment injuries that are directed related to health care (ibid at 4). The voluntary scheme was replaced by legislation which came into effect on 1 January 1997 and is based on the compensation rules of the voluntary patient insurance, with certain important changes.

Every provider of health care, in any form, is required to purchase patient insurance. One requirement for compensation is that the injury must have occurred to the person in connection with his or her being a patient, ie there must be a cause or relationship between the injury and the health care service (ibid at 7 & 8). Patient injury compensation is allowed for an injury caused by an examination, care, treatment or similar procedure provided that the injury could have been avoided by a different manner of performing the procedure in question, or by the choice of some other procedure available which could have satisfied the medical requirement in a less risky manner. The standard of care used in the assessment of this is that of an experienced specialist or other experienced professional in the field concerned. 8,000 claims per year were made in 1999 and 2000. Half were denied because the injury was not avoidable.

The scheme is administered by a Mutual Insurance Company owned by the County Councils. The Company finances and purchases all the services needed. The County Councils pay for the insurance – a patient can't buy "patient insurance". A private practising doctor has to have his/her own patient insurance. As the introduction of patient insurance has separated the liability issue from the compensation issue, there is no risk for a doctor in notifying the Mutual Insurance Company of a claim. In fact medical personnel are usually those who initiate the injury report. A benefit of the insurance scheme has been that a basis has been created for increased confidence between health care personnel and the patient as a patient no longer needs to prove fault on the part of the health care provider (ibid page 4).

120,000 cases have been dealt with since the scheme started. The Mutual Insurance Company is starting to provide data resulting from the analysis of these cases to hospitals to enable hospitals to do a comparison with data from the national level to judge their own performance.

In addition to feedback of data, another method used to change the way things are done is for feedback to be provided at seminars and conferences. As an example, a doctor working with the Mutual Insurance Company is analysing 100 cases of laparoscopic surgery where things went wrong and will present his findings to a meeting of the Royal College covering surgeons to facilitate discussion. The Mutual Insurance Company also meets with the hosts of the Quality Registers to see if the same problems are shown in their data.

The problem in improving the quality of health care is in changing the way doctors do things. It is recognised that a lot of factors will have influenced how a particular procedure was performed by a doctor – therefore routines, protocols, and culture within a hospital need to be discussed within the hospital when a problem occurs. It is not sufficient to just focus on the individual (Caj Essinger, Executive Director, County Councils & Regions Mutual Insurance Company).

Patients' Advisory Committee

Patients' Advisory Committees were founded in 1981 to be a complement to the Health and Medical Services Disciplinary Board (HSAN) to try to solve the problem (rather than determine right or wrong as is the responsibility of the Board). The Patients' Advisory Committee (PAC) is the problem solver. There is one PAC in every County, ie approximately 23 in Sweden. The law requires the PAC to work quickly and not in a bureaucratic way.

The PAC has four roles:

1. Patients – to help patients and their relatives with their problems in contacts with health care personnel;
2. Personnel – to arrange conferences to bring problems to the attention of health care personnel in order to prevent future occurrences. An example is of a large number of reports of patients in aged care facilities complaining of lying in pain with broken hips and health care personnel not believing there was a problem. Conferences and seminars were arranged to assist personnel in diagnosing breakages. The PAC publishes articles on such matters in the County Council paper;
3. Prevention – the PAC in Stockholm has kept a database since 1982. It reports back to the National Board and authorities to help in prevention. There is some collaboration with a university which compares data with its own. Statistics provide some validity to anecdotal analysis from PAC. PAC also meets with Patients' Unions (of which there are many, one for every disease);
4. Volunteered companions, ie to provide voluntary companions for patients who are kept in hospital against their will for psychiatric treatment.

PAC is independent – politicians on the Committee and the staff must not have any connection with bodies against whom complaints can be made. By being situated within the County Council, PAC can work more efficiently, practically, and informally. One of the most important tasks of the Committee is to give feedback to health care providers. In cases where there is a matter of principle and PAC thinks it can change the system, it takes the matter to the Council. It makes statements and gives suggestions for improvements from the complaints and criticisms the patients and their relatives have made. There are approximately 25 of these cases per year. PAC then follows up with the institution a year after resolution of the matter to ensure that the institution put in place the changes it said it would. PAC reports to the National Board every year and has discussions with them.

THE NETHERLANDS

The Netherlands has a population of approximately 15.6 million inhabitants. The structure of the health care system is a mixed private/public insurance-based system. Nearly all health facilities are privatised and hospitals are run on a non-profit basis. Doctors are mainly private practitioners. The central government has a role in the quality of care which includes responsibilities for providing legal titles to health care professionals, supervision and ensuring accessibility of health care. (Norlund & Edgren, op. cit. at 135).

The Health Care Inspectorate was founded in 1995 and has the main tasks of enforcing statutory regulations relating to public health, and advising and informing the Minister and the Director-General of Public Health on matters relating to public health either on request or on its own initiative. In practice, the enforcement is realised by monitoring and

investigating the health and medical service on quality and risks. The activities vary from consultation and advice to providing incentives, inspections and taking action or imposing sanctions. The *Health Act* empowers the Health Care Inspectorate to carry out its activities in an independent and autonomous way. Ultimately the Minister of Health is responsible for the Inspectorate's activities, but it is very unusual that the policy of the Inspectorate is questioned (ibid at 141).

Before 1995 the Health Care Inspectorate dealt with all complaints in the Health and Medical Service. Since the end of 1996 the Health Care Inspectorate has not had the obligation to manage patient complaints, except if the complaint relates to a very serious accident. The Inspectorate is obliged to evaluate the yearly report of the Complaint Committees and review how hospitals and doctors have responded to patient complaints. Although the yearly reports from the Complaint Committees to the Inspectorate are not comparable due to a non-uniform way of registration, a national register containing information on complaints is being developed (ibid at 142).

There are three forms of supervision of hospitals carried out by the Health Care Inspectorate aimed at examining conditions such as good equipment and procedures, enough health care personnel and a well functioning organisation in hospitals: common, thematic, and crisis or intervention supervision.

The common supervision investigates the whole organisation in terms of high standards of care. In thematic supervision, several hospitals are investigated at the same time to get a national overview in a specific area. Information about the effects of government policy as well as shortcomings in the health and medical service can be obtained by these investigations. Crisis or intervention supervision takes place in cases of calamities, like unexpected incidents and severe accidents. There is no legal obligation on the health care provider to report these calamities, but recommendations to institutions are laid down in a folder from the Health Care Inspectorate. In most cases the health care provider is responsible to investigate the incidents or accidents and write a report about the cause and how it can be prevented from recurring. If necessary, the Health Care Inspectorate can take action to reduce the risk. Statistics of the calamities are collected in a national register (ibid at 142).

There are two kinds of doctors in the Netherlands – GP's and specialists. The Minister of Health is responsible for the medical list (the BIG register). The Royal Dutch Medical Association, KNMG, a Federation of Associations of Medical Practitioners such as family physicians and medical specialists, is responsible for the training and registration of specialists.

Doctors seeking registration as specialists apply for registration after finishing special training developed by KNMG. Once granted, registration is good for five years, after which the specialist must apply again and must prove they have worked as a specialist and kept up with new developments. Some specialties require their specialist to complete a minimum of 40 hours per year of CME – however KNMG cannot yet demand this as it is not required by law.

Once registered, non-specialist doctors do not need to re-register, ie registration is for life. The government is currently discussing a requirement for re-registration but the issue is a political one.

A new law is proposed which will require specialists to complete 40 hours a year of accredited continuing medical education and to be assessed in the workplace every five years. In practice most specialist societies already require their members to fulfil both of these requirements in order to re-register (Swinkels J A. 'Re-registration of medical

specialists in the Netherlands.' *BMJ* 319:1191, 1999). The law was proposed to come into force in January 2000 but concepts are still in discussion in KNMG and need to be resolved, following which the government must approve the legislation and various rules be worked out.

The formal re-registration system for specialists was introduced in 1991 to accommodate the growing need for external accountability, the ageing of specialists and the notion that doctors should stop practising at 65, the rapid expansion of medical knowledge and technology, and the expansion of activities to assure the quality of specialist care, such as CME and Peer Review. (ibid).

Re-registration was linked to the existing system for the registration of specialists. Initially the criteria were exclusively quantitative, being linked to the amount of time spent in practice – eg surgeons could remain on the register if they had done at least 20 hours of surgery a week in the past five years; psychiatrists had to have practised for at least 8 hours a week. The scientific societies of medical specialists were invited to develop qualitative criteria for assessing medical performance. In 1986 the Dutch council for public health published a report on the quality of professional medical performance which can be seen as an organising principle for the qualitative criteria for re-registration. Three dimensions were distinguished which covered all aspects of doctors' work, as follows:

1. Technical – methodological
 - development of practice guidelines
 - peer review (quality of technical performance) by medical audit
 - continuous medical education
 - training of medical specialists
2. Interpersonal process
 - patient information and education
 - communication between doctors
 - peer review by medical audit on and training in attitude and communication
3. Organisational
 - visits to the medical practice (organisation) by peers in and outside hospitals

Some of these activities were already done voluntarily and others are enforced by law. Peer review of specialists was established and accepted by all parties, including the government, in the 1970's. The Institute for Quality and Health Care, which is financed by a supplementary charge on the daily price of hospital beds, was established in 1976 to support peer review. Visits to the place of practice were started voluntarily by the specialist societies in the early 1990's. The government is partly financing the visits to encourage this form of self-regulation (ibid).

Every medical specialist, whether working alone in private practice, in a group practice, or hospital, is visited. The person and the organisation must fill in forms for self-evaluation which are not aimed at identifying problems but at starting improvement. A visit is then made by three peers (one who has recently been visited, one who is due to be visited, and a chairperson). The visiting group meet with the specialist themselves, the district general practitioners, the hospital board, and the chairman of the medical staff of the hospital. They then visit the department and the diagnostic facilities. At the end of the visit they meet with the specialist to give their immediate conclusions, following which a full report is sent to the specialist within a few weeks. An appeal is possible. A weakness of this system is that the

penalties and sanctions are not yet systematically organised – each society currently has its own rules for penalties.

Disciplinary law is the standard instrument for preventing incompetent medical practice. In 1995 a new law covering the health care professions was passed. The law no longer restricts the practice of medicine to doctors – however the professional title (doctor) is protected. The law also lists procedures that may be performed only by a specific profession and replaces the disciplinary law then in existence.

The law also makes re-registration a legal requirement. It allows for two methods of re-registration – working in a practice that is evaluated by peers or CME. This law will need to be amended to take account of the proposals requiring a visiting system and CME. There are also difficulties with financing the re-registration demands.

The impetus for these proposals lies within the profession itself – the profession does not want doctors to train and then just sit back. Hospitals are also demanding that doctors keep up with developments in their fields.

UNITED KINGDOM

The medical profession in the United Kingdom is regulated by the General Medical Council under the *Medical Act 1983*. There are 200,000 doctors registered in the UK, 110,000 of whom are in active clinical practice.

The GMC has 104 members, 54 of whom have been elected by the doctors on the register of medical practitioners. Twenty-five other medical members are appointed by universities with medical schools, and by the medical royal colleges. Twenty-five members are lay people who represent the public. Under proposals for changes in the structure of the GMC, the number of members would be reduced to 35, 14 of whom would be lay members.

Professional Performance

In September 1997 performance procedures came into operation. They have been described as "the most important extension of the GMC's powers since it was set up in 1858" (GMC News, Spring 1997 page 4). The main purpose of the procedures is to protect patients from doctors whose performance is seriously deficient. "Seriously deficient performance" is defined as "a departure from good professional practice, whether or not it is covered by specific GMC guidance, sufficiently serious to call into question a doctor's registration". Under the procedures, doctors are given the opportunity to take remedial action. Where necessary, their registration is suspended.

Complaints regarding performance may be made by a patient, other members of the public, a colleague, an employer or someone in an official position who believes a doctor's pattern of professional performance is seriously deficient. 30% of complaints received by the GMC are not within the GMC's jurisdiction. A further 30% are referred to other agencies such as the National Health Scheme (NHS), Mental Health Act Commission, Data Protection Agency, because they can be more appropriately dealt with by the other agency. The GMC only takes a matter forward if a matter appears to be serious enough to warrant de-registration of the medical practitioner. The GMC is therefore the apex of the pyramid for complaint receipt, with the NHS being the first level and the National Clinical Assessment Authority (the government body) the second level.

30% of complaints are taken forward to the screening stage. The decision about where the complaint should go is now made by case workers of the GMC. Until approximately two years ago the decision used to be made by the Council.

The latter third (ie those that are taken forward to the screening stage), will be screened by a member of Council to see if there is an issue of performance or conduct. A member of staff will have already made a presumption about which route the complaint will take. The definitions of "conduct" and "performance" applied during the screening test are:

Conduct – raises an issue of professional conduct, so the screener is not really looking at the evidence. This is effectively a very low level.

Performance – a reason to suspect there is a deficiency in performance. This is a slightly higher level than for conduct.

The GMC is currently working to get the screening decision made more quickly – there used to be delays. The screening system is a "screening out" system rather than a "screening in" system. At present, 50% of complaints are screened in and 50% screened out. Where a complaint is screened out, the screener can give informal advice to the medical practitioner.

When a complaint is identified as being a performance matter, the GMC write to the doctor and ask him/her to send in written comments. After considering the information, the screener can invite the doctor to be assessed. The doctor can ask the screener to review the decision. This step is a safeguard for the doctor which was inserted in the procedure as a result of lobbying on behalf of doctors. There are four or five points at which the doctor can ask for review. The doctor can appeal the screener's decision (on review) to a Review Committee. This appeal procedure is rarely used now because doctors' organisations realise that the GMC would not refer the complaint unless there was good cause.

If there is evidence that a clear and immediate danger exists to patients or others, the screener can refer the case to the Preliminary Proceedings Committee. This Committee can act quickly to suspend a doctor's registration pending a full hearing.

If a doctor refuses to be assessed, the doctor is referred to the Assessment Referral Committee (ARC). Both the complainant and the doctor are able to address the Committee, which will decide whether assessment should go ahead.

If the doctor's performance is to be assessed, another GMC member will take over as "case co-ordinator". A team of two doctors and one lay assessor (not GMC members) is then appointed to carry out an assessment of the doctor's practice. The team will be led by a doctor from the specialty (eg, general practice, surgery) of the doctor undergoing assessment. The assessors apply a very sophisticated assessment tool which has been devised with the assistance of medical academics. Assessment methods for the major specialties in medicine have been developed with the Royal Colleges and other professional bodies. The assessments are tailored in every case to the doctor's actual practice including their specialty and grade. The doctor completes a portfolio (comprising 70 pages) before the assessors start. The question being asked is whether the doctor can do what he/she currently does. The assessors devise the preliminary shape for questions to be asked on the day based on a skeleton (ie standard format) used for all assessments. The portfolio completed by the doctor will guide the assessors about what they need to look at.

Phase 1 of the assessment comprises two days spent by the assessors at the doctor's work place. A case review is undertaken – the assessors look at the doctor's notes, interview the person who complained, colleagues and others who can provide information about the

doctor's performance, and interview the doctor (the interview may illuminate the doctor's attitude as revealed by his/her notes, eg a presumption to operate rather than look at alternatives). The assessors may observe how the doctor carries out consultation – they may also test the doctor's professional knowledge and skills.

The assessors record the data according to three standards: acceptable practice, cause for concern, unacceptable practice. 700 pieces of data are recorded. The assessors thereby build up a very good triangulated (cross referred) assessment of the doctor's practice. The data is then measured against the standards for good practice published by the GMC. The lead assessor then prepares a report, including narrative.

Phase 2 of the assessment involves the doctor coming to a place of assessment where his/her practical skills are assessed using equipment and dummy patients (being actors who are paid). The results are analysed against the results of doctors who volunteered to run phase 2 before the implementation of the performance procedures. In theory the GMC could decide not to do phase 2 if everything was satisfactory in phase 1, but in practice phase 2 is done even in these circumstances.

A final report is then generated which is circulated between the assessors. The report contains a profile of the doctor's performance, any problems with it, and if appropriate, the assessors' opinions on what the doctor needs to do to improve his/her performance and protect patients. The report is sent to the doctor who has 21 days in which to comment. The report and doctor's comments are sent to the Case Co-ordinator. The GMC has three options – to take no action, to refer the matter to the Committee on Professional Performance (CPP), or to ask the staff to try to strike an agreement with the doctor about requirements on practice, specific to the doctor's circumstances and the problems identified.

The GMC decides on the next step. Cases requiring further action will follow one of two routes:

The committee route – if assessment reveals problems, or the doctor refuses to co-operate at any stage, the case will be referred to the CPP. The CPP will decide whether to take action against the doctor's registration, which could include suspension or restriction of registration.

The voluntary route – if the doctor is co-operating, and the GMC is satisfied that the public is protected, the CPP need not become involved. Remedial action will be taken, followed by re-assessment to see if the problems have been solved. The review might show that the period needs to be extended or that the doctor needs to be referred to the CPP.

Whether the committee route or the voluntary route is followed, the GMC states that the public comes first. The GMC will conclude a case only when it is satisfied that the deficiencies in the doctor's performance have been put right.

Committee on Professional Performance

The hearings of the CPP are not held in public but the names of doctors whose performance is found to be seriously deficient goes on the public record. Doctors appearing before the CPP are entitled to legal representation. A panel of about seven members of the CPP, including two lay members (all members of the GMC), hear each case. At the hearing, the panel receives expert advice from one or more independent specialist advisers, and a legal assessor is present to advise on points of law. If the CPP decides the doctor's professional performance has been seriously deficient, it may:

- suspend his/her registration for up to 12 months; or
- place conditions on his/her registration for up to 3 years.

At the end of a period of suspension, or when conditions are due to be removed, the CPP reconsiders the case and decides, on the basis of the evidence, whether it can be closed or whether further action is needed. A doctor has 28 days to appeal to the Judicial Committee of the Privy Council, on a question of law only. At any stage of the procedures, a doctor can decide to retire by voluntarily taking his/her name off the register. There is no stigma in voluntary removal. However, if the doctor later applies to be registered, the GMC may want to look at his/her performance.

Ultimately it is the responsibility of the doctor to get the remedial training – the attitude is that as the doctor has allowed him/herself to get to this point of deficiency it is his/her responsibility to re-train. Doctors in the NHS will be referred back to the regional postgraduate dean who will devise a program for them.

It will be open to NHS Trusts to provide financial support for remedial action for doctors employed by the NHS, principally hospital doctors. The Secretary of State has indicated that NHS general practitioners should have broadly the same chance to remedy deficiencies in their performance as non NHS GP's. Doctors who have no NHS practice are responsible for making their own arrangements, either individually or through their employers.

The focus of the performance procedures is remedial rather than punitive. The process is designed to identify reliably doctors who need to take remedial action, while protecting patients.

It currently takes six months for a complaint to be screened and then five months to have the doctor assessed and a decision made. The GMC is trying to improve the speed and efficiency of performance procedures. However there is a concern that even if the time taken to complete the process is reduced, for example, to five to six months, that that period will still not be acceptable. This is particularly so as throughout the period the doctor is practising. A question being asked is whether this is acceptable when there is a question mark over their practice.

Legislative Framework

The powers of the GMC in relation to performance are contained in the *Medical Act 1983* and rules made under the Act.

Part V of the Act relates to Professional Conduct and Fitness to Practise. Part V comprises sections 35 - 45. Section 35 provides that the powers of the GMC shall include the power to provide, in such manner as the Council think fit, advice for members of the medical profession on standards of professional conduct or performance or on medical ethics. Sections 35A and 35B contain power to require disclosure of information for the purpose of assisting the GMC or any of its committees in carrying out functions in respect of professional conduct, professional performance or fitness to practise (section 35A) and the GMC's notification and disclosure obligations (eg to an employer) regarding a decision to, for example, invite a practitioner to agree to an assessment of his professional performance (section 35B).

The principal provision providing powers regarding professional performance is section 36A. Schedule 4 to the Act empowers the GMC to make rules governing proceedings before, inter alia, the Committee on Professional Performance. The rules may relate to the procedure of and evidence before the Committee and assessments. Schedule 4 also

includes provisions relating to the role of legal assessors; service of notification of decisions; extension of time for appealing; the taking effect of directions for erasure, suspension or conditional registration and of variations of conditions of registration; and the recording of directions for suspension or conditional registration.

In pursuance of the powers contained in Schedule 4, the GMC has made the General Medical Council (Professional Performance) Rules 1997. The Rules govern the following:

- referral to the Interim Orders Committee
- screening
- assessment
- Assessment Referral Committee
- procedure following assessment
- Committee on Professional Performance
- restoration applications
- general provisions relating to, for example, service of documents, meetings and procedure of committees.

Revalidation

In 1999 the GMC decided that the register of medical practitioners should become an up to date statement of each doctor's fitness to practise. Doctors will have to show regularly that they maintain the competence that secured their initial registration.

To satisfy the GMC that they are fit to practise, doctors will be expected to demonstrate their performance against the principles of good medical practice in all the fields in which they practise. The information for revalidation will need to be collected and assessed under seven general headings:

- good clinical care
- maintaining good medical practice (keeping up to date)
- teaching and training, appraising and assessing
- relationships with patients
- working with colleagues
- probity
- health

As 90% of the UK's doctors work in the National Health Scheme (NHS), the Government has agreed that the NHS will do appraisals of practitioners against the standards set by the GMC published as "good medical practice" (explicit standards of professional practice) every year and these will be pulled together after five years and sent to the GMC. As the GMC needs to quality assure it may need to look at the source material from time to time.

Doctors not in the NHS who have practising privileges in private hospitals will be appraised by the private hospitals. Doctors in private practice who do not have practising privileges will need to send their source materials to the GMC. Some colleges will perform surrogate appraisals of private practitioners by arrangement.

The GMC expects that most doctors will be granted a licence to practise at the end of the revalidation process. Doctors who choose not to participate in revalidation will be able to stay on the register without the entitlement to exercise the privileges currently associated with registration.

If concerns are raised about a doctor's fitness to practise during the revalidation process, he or she will be referred to the GMC's fitness to practise procedures. In this event, a number of outcomes are possible, including conditions on registration or suspension.

CONCLUSIONS

- The goal of programs developed by medical registration bodies to protect the community from a doctor whose standard of professional performance is poor should be to raise the standard of practice of the whole profession, not just that of the individual problem doctor.
- Programs should be educational rather than punitive or disciplinary.
- Monitoring should not be implemented without the provision of enhancement opportunities.
- Feedback to individual doctors should be integrated with the monitoring system.
- Information gathered in performance assessment should not be used in disciplinary proceedings except in certain circumstances such as where conduct constitutes a serious perceived risk to the public or a serious breach of ethics.
- The bodies administering performance assessment programs must have adequate powers, for example, to compel co-operation in the provision of information and records required for evaluation.
- Key terms such as "performance" should be clearly defined.
- Legal protection must be afforded to all who participate in the process, eg assessors, notifiers.
- Maintenance of professional competence should be recognised to be an ethical obligation.
- Access to quality educational activities should be promoted by medical registration bodies for individuals and groups.
- A one-to-one method of remedial teaching should be employed where beneficial and possible, for example tutorship/mentorship.
- Regulatory bodies should be alert to the role played by systems failures when looking at individuals' performance – and make recommendations for improvement.
- Guidelines or guidance for good medical practice should be issued to guide members of the profession.
- Regulatory bodies should work in partnership with other medical organisations such as the specialist medical colleges and associations representing members of the profession.
- Data on adverse outcomes should be gathered centrally and fed back to health care providers, policy makers and politicians.

RECOMMENDATIONS

- All medical boards in Australia should have powers which enable them to protect the community from the doctor whose standard of professional performance is poor.
- There should be national co-ordination of initiatives taken by the medical boards in this area to ensure consistency of approach and scope.
- Initiatives should have as their focus the enhancement of the quality of medical practice in general rather than the identification of “bad apples”.
- Such initiatives should take into account the conclusions listed on p.37.
- Renewal of registration should be dependent on demonstration of fitness to practise.

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