A working model for the extraordinary review of clinical privileges for doctors and dentists in the Australian Capital Territory

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Abstract. The extraordinary (unplanned) review of clinical privileges is the means by which an organisation can manage specific complaints about individual practitioners’ clinical competence that require immediate investigation. To date, the extraordinary review of clinical privileges for doctors and dentists has not been the subject of much research and there is a pressing need for the evaluation and review of how different legislated and non-legislated administrative processes work and what they achieve. Although it seems a fair proposition that comprehensive processes for the evaluation of the clinical competence of doctors and dentists may improve the overall delivery of an organisation’s clinical services, in fact, little is known about the relationship between the safety and quality of specific clinical services, procedures and interventions and the efficiency or effectiveness of established methodologies for the routine or the extraordinary review of clinical privileges. The authors present a model of a structured approach to the extraordinary review of clinical privileges within a clinical governance framework in the Australian Capital Territory. The assessment framework uses a primarily qualitative methodology, underpinned by a process of systematic review of clinical competence against the agreed standards of the CanMEDS Physician Competency Framework. The model is a practical, working framework that could be implemented on a hospital-, area health service- or state- and territory-wide basis in any other Australian jurisdiction.

What is known about the topic? In Australia, there is a national standard for credentialing and defining the scope of clinical practice for doctors working in hospital settings. However, there are no published reports in the national arena on established processes for the extraordinary review of clinical privileges for doctors or dentists and, despite the major inquiries investigating health system failures in Australian hospitals, the effectiveness and adequacy of existing processes for the extraordinary review of clinical privileges has not yet been prioritised nationally as an area for improvement or reform. Internationally, health care organisations have also been slow to establish frameworks for the management of complaints about doctors or dentists.

What does this paper add? This paper makes a significant contribution to the national and international safety and quality literature by presenting an exposition of a working model for the extraordinary review of clinical privileges of doctors and dentists. The authors describe a methodology in the public health sector that is territory-wide (not hospital-based), peer-reviewed, objective, fair and responsive. Because the model is a practical, working framework that could be implemented on a hospital-, area health service- or state- and territory-wide basis in any other Australian jurisdiction, this paper provides an opportunity for policy makers and legislators to drive innovative change. Although incursions into the provision of care by other health professionals have been avoided, the model could be readily adopted by clinical leaders from the nursing and allied health professions.
What are the implications for practitioners? An organisation dedicated to investigating serious complaints with a real sense of urgency, objectivity and transparency is far less likely to foster a climate of disquiet or anger amongst staff, or to trigger concerns of a ‘cover-up’ or disregard for accountability than an organisation not adopting such an approach. Anecdotal experience suggests the model has the potential to minimise, if not prevent, the occurrence of the kinds of complaints that become much-publicised in the media. This is positive because these types of damaging high profile cases often have the effect of diminishing community confidence in the health care system, in particular, confidence in the medical profession’s ability to self-regulate. Often, they also lead to a misrepresentation of the medical profession in the media, which is unfair since the overwhelming majority of doctors do meet the standards of their profession.

The strategic context

Data exist to demonstrate that hospital admissions may be associated with adverse outcomes, including permanent disabling injury and death.1–4 Although the incidence of adverse events reported varies between 2.9–10.6%, the actual number is clearly less important than doing something to prevent them.5,6 On the premise that human errors are inevitable,7 iatrogenic injury to hospitalised patients is not surprising. That said, there are opportunities to reduce this type of injury since at least half of the adverse outcomes reported in the literature are deemed highly preventable.1–4 The primary goal in the administration of health care should be to put in place strategies to minimise, and where ever possible prevent, the occurrence of avoidable human error. Still today, however, efforts to identify and understand vulnerabilities in the health care system that cause iatrogenic injury continue to challenge policy makers and legislators.

As data on the risks associated with being a patient in the health care system accumulate, consumers are becoming increasingly aware of, and knowledgeable about, what is an ‘appropriate’ standard of care across the different health professions. In the Australian Capital Territory (ACT), as in other Australian jurisdictions, there is a community expectation that health care facilities will engage competent clinicians, sufficiently capable of, and properly qualified to perform, work activities at a level acceptable to peers. This requires a system for the evaluation of clinical competence in the context of organisational need and capability. From an organisational perspective, it seems to make sense, at least in the first instance, to focus on the provision of care by doctors and dentists. This is not only because of the significant contribution these professionals make to the health care system, but also because of the already established processes within these professions for the credentialing and re-credentialing of clinical privileges to delineate the extent of a doctor’s or dentist’s clinical practice within a health facility based on the individual’s credentials, competence, performance and professional suitability, and the needs and the capability of the health facility to support the doctor’s or dentist’s scope of clinical practice.8

A systems approach to error in health care

As with other hazardous industries, such as aviation, a systems approach to safety improvement is generally recognised as the best means of dealing with many of the problems that occur in health care.9–12 The Swiss cheese model of system accidents shows how breaches of layers of defences, barriers and safeguards can be penetrated by an accident trajectory so that seemingly minor errors in one area of a health care organisation combine with errors in other areas to result in an adverse event.13 Of course, a focus on the design of systems to minimise human error redefines, but in no way lessens, personal accountability; whilst health care organisations are responsible for designing safe systems, individual practitioners maintain responsibility for delivering safe, quality care within those systems.10–12 In this way, the clinical competence of individual practitioners is relevant where ever a systems approach to error in health care is taken.

The routine and extraordinary review of clinical privileges

In Australia, there is a national standard for credentialing and defining the scope of clinical practice for doctors working in hospital settings.8 Developed in 2004, the standard is aimed at improving administrative processes for the routine review of clinical privileges, for credentialing and re-credentialing purposes and, since it is based on common principles, could apply equally to dentists (and nurses and allied health professionals) in a broad range of clinical settings.

In terms of safeguarding patients, the routine review of clinical privileges can identify issues around suboptimal performance. However, most committees tasked with the oversight of the medical and dental appointment and re-appointment processes undertake routine re-credentialing and review of clinical privileges at defined intervals, often on 2–5 year cycles. For this reason, having a process in place for the extraordinary (unplanned) review of clinical privileges is critical because this is the means by which an organisation can manage a specific complaint about an individual practitioner’s clinical competence that requires immediate investigation.

Inquiries into health system failures in Australia

In the past few years, there have been a series of inquiries investigating health system failures in several public hospitals across Australia.14–17 Most of these failures stemmed from mishandled concerns about poor clinical performance and have been attributed, at least in part, to inadequate clinical governance arrangements, including the absence of policies and established procedures for dealing with poor clinical performance.18,19 Of those lessons learned, a recurring theme is that the management of clinical competence at an
organisational (or systems) level is an important aspect of good clinical governance.

Underperformance and the threat to safe patient care

Leape\textsuperscript{10} has presented a detailed discussion of factors that can affect underperformance within the medical profession noting that, at one time or another, \textasciitilde{}1 out of 3 doctors in North America will have a problem that poses a threat to safe patient care. This may be because of a variety of reasons, including psychopathology, intellectual or physical impairment, behaviour or declining competence. Whilst acknowledging there are no overall estimates of the extent of knowledge or skills deficiencies in the medical profession, based on failure rates for specialty board re-certification examinations, it has been estimated that, at some point in their career, as many as 10\% of doctors will demonstrate significant deficiencies in knowledge or skill.\textsuperscript{9} The issue of suboptimal performance is clearly not an insignificant one.

Since there is no reason to suggest the North American data would not readily translate to the Australian context, or that they would be necessarily limited to the medical profession, it seems logical for health care organisations across Australia to have systems in place that are capable of dealing quickly and openly with serious complaints about the competence of a doctor or dentist (and any other health professional). There are, however, no published reports in the national arena on established processes for the extraordinary review of clinical privileges for doctors or dentists and, despite the major inquiries investigating health system failures in Australian hospitals, the effectiveness and adequacy of existing processes for the extraordinary review of clinical privileges has not yet been prioritised nationally as an area for improvement or reform. This is notable because anecdotal experience suggests the rigour with which existing processes are conducted varies considerably, and that much of the work is undertaken on an ad hoc basis, often only after there has been negative media scrutiny or public discussion, triggered by an egregious series of events, demanding action be taken. Internationally, health care organisations have also been slow to establish frameworks for the management of complaints about doctors or dentists.\textsuperscript{9} Whilst on one hand, this exposes an apparent limitation on the part of health care organisations globally, it also presents an enormous opportunity for policy makers and legislators to drive innovative change.

Aim

This paper presents an exposition of a working model for the extraordinary review of clinical privileges of doctors and dentists engaged in the public health sector in the ACT. The authors describe, but do not evaluate, a methodology that is territory-wide (not hospital-based), peer-reviewed, objective, fair and responsive. Although incursions into the provision of care by other health professionals have been avoided, it is noted that the model could be readily adopted by clinical leaders from the nursing and allied health professions.

The local setting

ACT Health, the ACT Government’s Department of Health, is committed to reducing patient harm, and maintaining and improving the safety and quality of its health care services, through the delivery of high quality health care by competent health professionals in clinical environments that support safe service provision. Comprised of six clinical divisions and services, the organisation provides a comprehensive range of health services to a catchment population of \textasciitilde{}750,000, which includes residents from the ACT and south-eastern New South Wales (NSW) (see Table 1).

ACT Health clinical governance arrangements

ACT Health has established a robust set of clinical governance arrangements that enable strong leadership in, and strategic control of, key aspects of its clinical operations. Notably, there is one medical and dental appointments process for the six clinical divisions and services.\textsuperscript{20} This includes a common approach, by the Medical and Dental Appointments Advisory Committee (MDAAC), to the process for the management of the credentialing and re-credentialing of clinical privileges\textsuperscript{17,21} and a

Table 1. Clinical divisions and services of ACT Health

<table>
<thead>
<tr>
<th>Clinical division and service</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>1. The Canberra Hospital</td>
<td>500-bed public tertiary referral and trauma hospital for the Australian Capital Territory (ACT) and south-eastern New South Wales (NSW). Provides acute care inpatient, outpatient and emergency department (ED) services. Teaching hospital of The Australian National University (ANU) and The University of Canberra (UC).</td>
</tr>
<tr>
<td>2. Calvary Public Hospital</td>
<td>174-bed public district general hospital with a 19-bed hospice operated by the Little Co. of Mary Health Care ACT, part of Little Co. of Mary Healthcare Limited, owned by the Sisters of the Little Co. of Mary. Provides acute care inpatient, outpatient and ED services. Teaching hospital of the ANU and UC.</td>
</tr>
<tr>
<td>3. Mental Health ACT</td>
<td>Provides mental health services for the ACT and south-eastern NSW in hospital and community settings.</td>
</tr>
<tr>
<td>4. Community Health</td>
<td>Provides primary health services for the ACT community.</td>
</tr>
<tr>
<td>5. Aged Care and Rehabilitation Service</td>
<td>Provides aged care and rehabilitation services for the ACT in inpatient, outpatient, ED, sub-acute and community settings.</td>
</tr>
<tr>
<td>6. Capital Region Cancer Service</td>
<td>Provides cancer services for the ACT and south-eastern NSW in inpatient, outpatient and community settings.</td>
</tr>
</tbody>
</table>
common approach, by the Clinical Privileges Committee (CPC), to the management of a complaint or concern about the clinical competence of a doctor or dentist.\textsuperscript{22} In this way, the ACT Health Clinical Governance Framework, which identifies four strategic areas (clinical competence, clinical effectiveness, clinical risk management and systems enhancement and sustainability), includes a committee structure for the routine as well as the extraordinary review of clinical privileges for doctors and dentists.

**Regulatory framework in the ACT**

The CPC comprises one part of the health professional regulatory system in the ACT, which consists of four main bodies (see Fig. 1). Fundamentally, the regulatory framework in the ACT has been designed to protect the public from harm, whilst supporting and fostering the provision of safe, high quality care. Complaints referred to the CPC pertain to issues of clinical competence, performance, outcomes and professional behaviour. Disciplinary and professional misconduct matters lie outside of the remit of the CPC and are investigated by the health professions boards, which have express powers to take action in relation to reports about health practitioners. The Health Services Commissioner deals with complaints about the provision of health services and services for older people, and is also involved in working with the health professions boards to maintain minimum standards in service provision and to protect public safety by ensuring health service providers meet suitability to practice requirements. The specialty colleges maintain the professional specialties across Australasia by providing education and training, setting standards of practice and assisting individual practitioners to meet and maintain those standards principally through their role as a training body. Whilst they do not have express powers to take action in relation to reports about health practitioners, some support the development of national and bi-national mortality audits to ensure standards of safe and comprehensive care, for example, the Royal Australasian College of Surgeons operates the Australia and New Zealand Audits of Surgical Mortality.

There are legislative requirements for how the health professional regulatory bodies in the ACT exercise their powers and perform their functions\textsuperscript{23–26} and, as permitted under the law, there are established links for the sharing of information. Since there is no single regulatory mechanism in the ACT, limitations of one system may be complemented by the strengths of another. Minimisation of the duplication of investigative processes is anticipated in time, as increasing system maturity leads to an improved understanding and appreciation of the system’s capacity for the escalation of investigative processes, and paths to de-escalation.

**The legislative environment in the ACT**

In the ACT, the requirements for the extraordinary review of clinical privileges for doctors and dentists are regulated by law.\textsuperscript{23} Approved clinical privileges committees conduct their business ‘in confidence’, meaning the confidentiality of documents created by, or solely for, these committees, and all committee proceedings, are protected from being released to the public.

**The ACT Health Clinical Privileges Committee**

The CPC was established as an approved public sector clinical privileges committee in September 2006. Its sole function is to conduct the extraordinary review of clinical privileges for doctors and dentists, and it does so independent of ACT Health management, in a non-punitive manner, with patient safety being the first priority. The CPC is capable of a rapid response to complaints and its peer review mechanism ensures matters are primarily investigated by peers mostly working within the ACT health system (see Fig. 2).

Before the establishment of the territory-wide CPC (and MDAAC), the divisions of ACT Health operated independent committee structures for the extraordinary (and the routine) review of clinical privileges. Over time, this approach was deemed unsatisfactory for several reasons: (1) because of an inability for divisional clinical privileges committees to readily share information with one another due to the confidentiality and protection of information generated by, and for the purposes of, individual committees; (2) because of the potential for varying levels of sophistication of processes to unfairly advantage or disadvantage doctors and dentists engaged with different clinical divisions and services; and (3) because of the obvious duplication of effort and resources. Since the majority of doctors and dentists employed by ACT Health are engaged at multiple divisions, it is clearly preferable to adopt a common approach in the ACT to medical and dental recruitment, credentialing and the delineation and review of clinical privileges. This reduces the potential for the development of a situation where the clinical privileges of a doctor or dentist engaged at multiple clinical divisions and services are amended or withdrawn in one division, but not another.

The CPC does not provide professional or personal support to doctors or dentists, but may facilitate the provision of such support. Since the focus of the CPC is to address complaints about the competence of individual practitioners, issues arising from a review that reflect systemic problems are referred for appropriate action to either the ACT Health Clinical Audit Committee (CAC) or the divisional Clinical Review Committee (CRC) of the relevant health facility where the doctor or dentist is engaged. Examples of systems issues that the CPC could refer to CAC, or a divisional CRC, for management include matters relating to the needs or capabilities of a division to support doctors and dentists to undertake their authorised scopes of clinical practice, such as infrastructure and resources, either human or physical.
**Types of review for managing a complaint about the clinical competence of a doctor or dentist**

ACT Health policy for the management of a complaint about the clinical competence of a doctor or dentist identifies three types of review that are descriptive, not prescriptive, intended as a guide to assist a Unit Director, or equivalent, in determining the most appropriate management action. The clear intent is for issues of perceived suboptimal competence to...
be identified, and managed, early, to prevent the escalation of problems (see Table 2).

**CPC administrative process for the extraordinary review of clinical privileges**

All Type B and Type C review investigations are conducted under the auspices of the CPC, which has power to recommend: that the clinical privileges of a doctor or dentist should stay the same or be amended or withdrawn; that the terms of engagement of a doctor or dentist by a health facility should be amended; or that the engagement of a doctor or dentist by a health facility should be suspended or ended.\(^{24,25}\) Except where a complaint is referred directly to the CPC, Unit Directors, or equivalent, act as ‘gatekeepers’, determining the type of review for individual complaints.

Any person can refer a complaint directly to the CPC, including patients and their families. This is important because, although clinicians in the ACT have a positive obligation to report all instances of impairment amongst colleagues,\(^{24,25}\) there will be circumstances where peers fail to report issues of underperformance for fear of a reprisal, or any other reason. Arguably, a reliance on whistleblowers in the early detection of underperformance is overly burdensome on clinicians and, once there has been a complaint, the whistleblower.\(^{27}\) A fairer process, consistent with a systems approach, shifts the responsibility back to the organisation by way of the early identification and management of performance problems by clinical leaders. This is the approach adopted by ACT Health, which is not without potential limitations. For example, in the literature, several factors have been identified that may affect the willingness of clinical supervisors to report poor clinical performance, at least for students and residents, including a lack of documentation or knowledge of what to specifically document, the anticipation of an appeal process or concerns regarding a lack of remediation options.\(^{25}\) For these reasons, in accordance with ACT Health policy,\(^{22}\) the CPC accepts complaints from members of the public and does not rely solely on Unit Directors, or equivalent, or peers to make reports.

The CPC exercises its functions guided by the rules of natural justice, including the disclosure of material evidence, the right to be heard, the right to have a decision based on evidence and the right to have a decision made by an unbiased decision-maker. Committee members recuse themselves from participation in a review on grounds such as bias, prejudice, personal involvement or any other interest in a matter being decided. Table 3 sets out examples of the types of information the CPC may obtain during the course of its investigation of a complaint, which form the basis of its recommendation in relation to the complaint. Elements of the Terms of Reference for a CPC review are summarised in Table 4. The CPC aims to deal expeditiously with complaints and, in most cases, can formulate its recommendation in relation to a matter at the conclusion of its second or third meeting.

**Assessment of competence**

In the ACT, doctors and dentists can expect that every extraordinary review of clinical privileges conducted under the auspices of the CPC will conform to the standards expected of any primarily qualitative methodology. Specifically, the committee’s assessment framework is underpinned by a process of systematic review of clinical competence against the agreed standards of the Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS 2005 Physician Competency Framework (‘the CanMEDS Framework’). CPC competency-based performance assessments are therefore not only structured but also reproducible. Of equal importance is that investigations are undertaken in accordance with principles of natural justice and that procedural fairness is constantly applied.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>A brief, informal review conducted when an isolated variance in outcome, which is non-fatal, leads to non-serious impairment or disability, is identified, or a near miss.</td>
</tr>
<tr>
<td>B</td>
<td>A formal review conducted when a variance in outcome that leads to a fatality, or serious impairment or disability, is identified, or a trend over time concerning clinical performance, behaviour, or practices that vary from peers’ or others’ expectations.</td>
</tr>
<tr>
<td>C</td>
<td>A formal extended review conducted when a pattern of sub-optimal, or serious gaps in, clinical performance, behaviour or practices is identified, or a variation in outcomes over time. This type of review may be internal or external to ACT Health.</td>
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**Table 3. Information the clinical privileges committee may obtain during the course of its investigation of a complaint**

<table>
<thead>
<tr>
<th>Evidence</th>
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<tbody>
<tr>
<td>Clinical records for all patients involved in the complaint under review.</td>
</tr>
<tr>
<td>Correspondence prepared by the complainant detailing the specific nature of the complaint in relation to the management of all cases by the doctor or dentist.</td>
</tr>
<tr>
<td>Agreed standard case-mix, incident and complaints data, patient outcomes information and any other performance data of the doctor or dentist.</td>
</tr>
<tr>
<td>The written defence of the doctor or dentist prepared for the Clinical Privileges Committee.</td>
</tr>
<tr>
<td>The Curriculum Vitae of the doctor or dentist and, where available, research publications.</td>
</tr>
<tr>
<td>Reports of previous investigations related to the complaint conducted by other committees within the organisation.</td>
</tr>
<tr>
<td>Reports of previous investigations related to the complaint conducted by other agencies external to the organisation (e.g. Human Rights Commission, Medical Board of the ACT, ACT Dental Board).</td>
</tr>
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Clinical outcome measures

In its assessment of competence, the CPC reviews the available performance data of the doctor or dentist from each clinical division and service where he or she has clinical privileges, in light of the reasonable standard of clinical competence as determined by local and national standards. Generally speaking, most health care professionals would consider the ultimate measure of competence to be assessed on the basis of clinical outcomes. Certainly, these measures of the quality of patient care can examine the end results achieved with specific procedures by individual practitioners, for comparison against established norms. The distinct advantages of an outcomes-focused approach to determining competence have been outlined elsewhere.29 Whilst this approach is not without significant challenges, clinical outcomes can be useful measures of competence because they are ‘...definable, easily discovered and reviewed, and serve as a reasonable proxy to other elements of competence, including technical skills, cognitive ability and clinical decision-making’.30 Of course, a sole focus on the application of medical knowledge and clinical skills in the provision of care neglects other important competencies needed for clinical practice.

Retrospective examination of patient clinical records

In addition to its review of the available performance data of the doctor or dentist, the CPC conducts a detailed, retrospective examination of the clinical records of all patients involved in each complaint to establish a full and fair account of what happened in relation to the complaint and identify patterns of suboptimal performance. This assessment of competence is made against the CanMEDS Framework. Certainly, it is not unreasonable to suggest that health professionals know the level of clinical competence required for their specialty area, and can judge both the quality and appropriateness of the practice of their peers. At the same time, however, it is important to acknowledge the real potential for the retrospective examination of a patient clinical record to reflect a general impression of the clinical performance or professional behaviour of a doctor or dentist, and thereby fail to conform to many basic standards of fairness, if there is no comprehensive framework in place to guide and standardise the identification of important domains of professional medical and dental practice.

Although the retrospective examination of patient clinical records does not measure technical competence directly, relying instead on the careful and objective expert opinion of CPC members, it is an important means of assessment of competence for the CPC, particularly in circumstances where facts are disputed or the course or causation of events is unclear. Individual CPC members review relevant patient clinical records independently, to draw their own assessment of competency but ultimately, majority agreement is reached on a collective decision that becomes the determination of the committee.

Rationale for the CPC application of the competency-based CanMEDS framework

Competency-based training, standards and assessment

Today, health professional training programs are being increasingly formulated on the basis of the definition of the specific roles required of the practising health professional and the identified competencies and learning objectives within those roles. The aim is to equip the ‘modern’ specialist practitioner with the knowledge, skills and also the attitudes required for practice in his or her chosen profession. This has led to a philosophic shift from the traditional emphasis on curriculum-based training and assessment towards a competency-based approach where curricula, standards and assessments are being reoriented to frameworks of applied professional abilities.31,32

Domains of professional competence

In the literature, professional competence has been defined as ‘...the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and
reflection in daily practice for the benefit of the individual and community being served.35 Today, this is the generally agreed-upon definition because it encompasses important domains of professional practice that do not just refer to key technical, cognitive and emotional aspects of practice. Internationally, the Accreditation Council for Graduate Medical Education (ACGME) in the United States of America and the RCPSC have each articulated comprehensive definitions of general or ‘core’ competencies that make explicit the traditionally implicit skill sets needed to be an effective health care professional beyond core medical expertise. Fundamentally, the ACGME and RCPSC core competencies are initiatives to improve patient care (see Table 5).

In Australia, although the Australian Medical Council (AMC), the state medical boards and the specialty colleges have identified a series of broad goals of specialist education and training, including professional development, they have not yet defined a set of general competencies needed for medical education and practice. Instead, the AMC Accreditation Guide refers training organisations to the models developed by the ACGME and the RCPSC. Most of the specialty colleges in Australia have adopted the CanMEDS,34 with some incorporating additions to the model to suit their specialty area. For example, the new competency-based Surgical Education and Training (SET) programme developed by the Royal Australasian College of Surgeons includes the additional roles of Judgement-Decision-Maker and Technical Expert and the ‘Manager’ and ‘Scholar’ CanMEDS domains of ability are referred to as ‘Manager-Leader’ and ‘Scholar-Teacher’ respectively.35

Although the CanMEDS core competencies are not formally integrated into every specialty college in Australia, it is clearly preferable for a review committee, such as the CPC, to adopt a categorisation of competencies that is applicable across all craft groups, rather than to match the competencies of a doctor or dentist to the model adopted by his or her respective college. Not only does this simplify the administration of the review process, it also ensures that specialist practitioners are neither advantaged, nor disadvantaged, by the varying levels of sophistication of competency processes across the different colleges.

### Table 5. Summary of the Accreditation Council for Graduate Medical Education (ACGME) general physician competencies and Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS framework

<table>
<thead>
<tr>
<th>ACGME general physician competencies</th>
<th>RCPSC CanMEDS physician competency framework</th>
</tr>
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<tbody>
<tr>
<td>Medical Knowledge</td>
<td>Medical Expert</td>
</tr>
<tr>
<td>Patient Care</td>
<td>Collaborator</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>Manager</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>Communicator</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Professional</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>Health Advocate</td>
</tr>
<tr>
<td></td>
<td>Scholar</td>
</tr>
</tbody>
</table>

**CPC recommendation in relation to a complaint**

The CPC forwards its recommendation in relation to a complaint to the Chief Executive (CE) once it has reached a majority, or unanimous, agreement. The CE is not bound by the action recommended by the CPC. The ACT Administrative Appeals Tribunal has jurisdiction to review the merits of a decision made by the CE.

**Remedial professional development**

The ostensible purpose of withdrawing the clinical privileges of a doctor or dentist is to protect the public by removing a dangerous clinician from practice. Of course, this is a last resort measure and in some circumstances, it may be appropriate for a doctor or dentist to undergo an individualised program of remedial action. One benefit of using the CanMEDS Framework for the assessment of the clinical competency of a doctor or dentist is that this enables the CPC to identify specific areas requiring remediation, which may assist in the development of goal-directed learning objectives. Success can then be determined using external markers of competence.

In developing individualised remediation programs, ACT Health ultimately aims to work with doctors and dentists to improve specific targeted deficiencies. There are, however, clear barriers to this. For example, staff may be reluctant to voluntarily participate as mentors or supervisors of remediation activities. There is also the potential for a lack of expertise to oversee a program, as well as issues regarding time and cost, particularly in a small jurisdiction like the ACT. Most notably, however, is the matter of patient exposure to a clinician with acknowledged deficits.9 Interestingly, although the clear intent is to facilitate improvement in clinical performance, there are overall few reports of studies assessing the efficacy of remedial professional development programs for poorly performing doctors and dentists.36

**Conclusion**

Early indications suggest the CPC has begun to develop the necessary reputation for independence, integrity, openness and rigour in its investigations and is well placed to provide a continuity of investigatory expertise. The substantial efforts of ACT Health in having developed an independent process for the extraordinary review of clinical privileges for doctors and dentists is notable. Although the primary objective is to maintain and improve the safety and quality of health care services delivered by doctors and dentists in the public sector in the ACT, this review process also protects doctors and dentists by ensuring that the environments within which they practise support and facilitate safety and quality.

Time will tell whether the CPC will have an effect on organisational culture in the ACT but it seems not unreasonable to suggest that an organisation dedicated to investigating serious complaints with a real sense of urgency, objectivity and transparency is far less likely to foster a climate of disquiet or anger amongst staff, or to trigger concerns of a ‘cover-up’ or disregard for accountability than an organisation not adopting such an approach. Anecdotal experience suggests the CPC model has the potential to minimise, if not prevent, the occurrence of the kinds of complaints that become much-
publicised in the media. This is positive because these types of damaging high profile cases often have the effect of diminishing community confidence in the health care system, in particular, confidence in the medical profession’s ability to self-regulate. Often, they also lead to a grotesque misrepresentation of the medical profession in the media, which is unfair since the overwhelming majority of doctors do meet the standards of their profession.

Future directions

The ACT Health experience demonstrates that a structured approach to the extraordinary review of clinical privileges within a clinical governance framework may meet the needs of the organisation, clinicians and the community by providing an opportunity to identify, and manage, concerns about the clinical competence of a doctor or dentist at an early stage. Notably, in the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to the ACT Health model, the CPC is an existing committee established to apply a standard set of investigative processes to

the nature of adverse events in hospitalised patients. Results of the Harvard Medical Practice Study II. N Engl J Med 1991; 324(6); 377–84.


References


12 Leape LL, Berwick DM. Safe health care: are we up to it? BMJ 2000; 320: 725–6. doi:10.1136/bmj.320.7237.725


16 Van Der Weyden MB. The “Cam affair”: an isolated incident or destined to be repeated? Med J Aust 2004; 180(3): 100–1.


21 ACT Health. Medical and Dental Appointments Policy. 2006.

22 ACT Health. Management of a Complaint or Concern About the Clinical Competence of a Doctor or Dentist Policy. 2006.


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