Chapter 5.1.7

CREDENTIALING AND RE-CERTIFICATION OF RURAL DOCTORS

Jane Greacen
Monash University, Australia

Introduction

Regulatory bodies, medical colleges, medical registration boards and employers in Australia are becoming increasingly stringent and focussed in their attempts to ensure that doctors are who they say they are, and that they have the skills they say they have , to ensure the safe provision of clinical care.

In the recent past, doctors in Australia could work in their specialty with minimal monitoring or review of their skills and qualifications. Hospitals and medical practices relied on the medical registration boards to check that the doctors' qualifications were authentic.

International medical graduates

Doctors who were trained and have work experience in Australia have often relied on word of mouth to have the quality of their clinical skills endorsed; and the state Medical Boards have access to their original qualifications. This is not so for doctors who were trained in other countries, however. Appropriate references are harder to obtain and qualifications may be from universities that are not recognised as delivering equivalent medical training to those in Australia.

International medical graduates (IMGs) face many hurdles to be able to practice medicine in Australia. They must work under supervision until they have achieved qualifications accepted by the relevant Australian college. While the supervision and assessment requirements for general practice (family medicine) are not as stringent as those for other specialities such as surgery, obstetrics, paediatrics etc, many doctors trained in these specialties end up working in general practice in rural Australia. IMGs are required to work in rural and remote areas (and some outer urban areas) when they come to Australia to contribute to programmes created specifically to address medical workforce shortages in these areas.

It took a disaster (see page 4 below) to change the policy environment , such that workforce shortages in rural areas was no longer justification for uncritically accepting doctors whose training, qualifications, experience and background may not be able to be verified.

Summary

In parallel with making the medical registration system more controlled, some states in Australia introduced more stringent credentialing and performance appraisal processes for doctors appointed to provide clinical services in hospitals and aged care facilities, and the national standards for hospitals were tightened substantially. Re-certification has not been introduced in Australia at this time (1).

Discussion

Communities expect their doctors to be the best, and to be able to treat their illnesses and injuries, save their lives, and provide high quality comprehensive care. They generally do not have the depth of knowledge to assess the competence of their doctors and must trust the systems established to do this for them.

Access to medical services is not equitable either within or between countries, and the reasons for this may include insufficient medical training facilities; skewed distribution of doctors (generally fewer in rural and remote areas and areas of lower socioeconomic status); and affordability of services.

The lack of availability of doctors to provide services can exert pressure on governments, hospitals and other medical service providers to accept doctors who may not meet the standards of the colleges or standards set by other professional bodies.

Medical colleges may or may not recognise the quality of training or the scope of skills required by medical colleges in other countries.

In Australia, more than 50% of doctors in rural areas are trained in other countries (2). The fact that Australian medical colleges may not accept a doctor's experience or qualifications does not necessarily mean that the doctor is not a competent and safe practitioner. Most IMGs provide excellent medical services to their communities particularly if they are given support and supervision until they are familiar with the regulatory environment and practice norms, and can meet the quality of clinical service expectations of their adopted country.

However, there are some doctors in some circumstances who provide poor quality, uncaring, and unsafe medical practice. There needs to be a way to protect the community from this, and so it is reasonable to expect the standards set by our medical colleges to be adhered to, and for doctors who fail to do so, to be able to be identified and remedial action taken.

Patterns and remediation

There is evidence that doctors who are disciplined by medical boards are more likely to be associated with previous unprofessional behaviour in medical school. 'Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behaviour' (3). There is also evidence that doctors who have complaints made against them to medical boards or to Health Commissioners more than once, are very likely to have more complaints made against them in the future (4).

While university medical schools may have remediation programmes for students who lack competence in certain areas, and/or whose personalities mitigate against their providing caring medical service in the future, they may not fail them nor divert them into what may be more appropriate careers. Similarly, junior doctors and doctors in training who work under supervision may receive advice about their performance, but are unlikely to be restricted in their scope of practice unless there have been serious incidents or misdemeanours.

The medical registration boards have remediation processes for doctors who have health concerns, or issues with conduct or competence, and are able to require those doctors to work under supervision or stop them from providing clinical services.

There is strong evidence that a small number of doctors account for a large proportion of complaints and that previous complaints and claims are an important predictor of future events (4). An assessment of formal complaints made against doctors in Australia over ten years, showed that fewer than 500 doctors accounted for a quarter of all complaints. This same research showed that doctors who had a third complaint made against them had 'a 38% chance of being the subject of a further complaint within a year, and a 57% probability of being complained against again within 2 years' (4). It is reasonable to surmise that current remedial actions by medical boards may not be effective, and that substantial harm continues to happen to patients.

It is clear that a stringent review of doctors' skills, experience and qualifications is justified whether they are trained in their homeland, or in another country, and that doctors should receive ongoing support to maintain and strengthen their skills during their careers.

The doctor at the centre of the disaster mentioned above was charged with manslaughter and accused of gross incompetence. He was already being investigated in the USA before he came to Australia, and neither the medical board nor the hospital that employed him had ascertained this fact (5).

Case Study: *Surgeon applying to work in a small rural hospital*

Australia has nationalised the medical registration boards, and as noted above, introduced more stringent medical appointment procedures.

This scenario is about a small rural hospital that has been recruiting a general surgeon. The hospital has two theatres that are quite well equipped, and nursing staff who are well trained and competent. The hospital has no intensive care unit, and is two hours' drive from a larger hospital that has those facilities. General anaesthesia is provided by competent procedural general practitioners (family physicians), who have appropriate qualifications and experience, but who are not specialist anaesthetists. The hospital has determined the range and complexity of surgery that it believes can be performed safely in its theatres and safe post-operative care provided in its wards.

It receives an application from a surgeon who is keen to work there and to relocate and live in the town. Without the process outlined below, the doctor was allowed to practice beyond the capabilities of the hospital, and possibly beyond his/her capabilities, as a result of which significant harm was inflicted on many patients.

Steps to assess the application:

1. The doctor is requested to provide comprehensive information and documentation including:
    a. Verified qualifications, a curriculum vitae, medical registration details, references (from credible surgeons in his/her field), a copy of their medical indemnity, and a statement about any claims made against them.
    b. The scope of surgery they wish to undertake.
2. Reference checks are completed independently by a medical practitioner on behalf of the hospital, and an internet search is undertaken to see if there is any negative press about the doctor.
3. The doctor is interviewed and his/her understanding of the implications of working in a small rural hospital is ascertained:
    a. They must understand the potential for them to work in relative professional isolation, and take responsibility for their patient before, during and after surgery in partnership with the general practitioners who provide in-patient care.
    b. They must understand the implications of not having access to an intensive care unit or perhaps of a specialist physician.
4. The doctor's commitment to his/her ongoing professional development, involvement with the hospital's quality and safety programmes, and the hospital's risk management programmes, is assessed and determined.
5. If the doctor does not have full registration, then supervision needs to be arranged, and the level of supervision will depend on the requirements of the relevant college.
6. If the doctor is an IMG whose qualifications are not recognised as equivalent, then arrangements will be made to support the doctor to engage in a pathway to qualification; this needs to be supported by the hospital.
7. The scope of practice needs to be considered to ensure that the doctor is aware of the range and complexity of surgery that he/she would be permitted to perform.

8. The above information is submitted to the hospital's Credentialing Committee (or regional equivalent) for consideration, with recommendations made about the doctor's appointment to the hospital, the scope of practice permitted, and the level of supervision required and how it is to be provided (if necessary).
9. Every 12 months, a performance review is undertaken, which includes an interview with the doctor if there is any concern about performance, and ensuring that medical registration, indemnity and professional development are up to date. Feedback from the doctor is also requested.
10. The hospital's requirements to meet mandatory national standards (6) state:
    '*The credentialling system to confirm the formal qualifications, training, experience and clinical competence of clinicians, which is consistent with national standards and guidelines, and with organisational policy, is evaluated, and improved as required'.*

Practice pearls

- All doctors appointed to provide medical services to hospitals and public aged care facilities undergo a comprehensive credentialing process; their scope of practice is defined and adhered to throughout their appointment.
- The credentialing process includes ensuring the doctor's medical registration is current; qualifications have been verified; there is no legal or medical registration board action pending or taken against them anywhere in the world; their reputation and integrity is unremarkable, and they are committed to maintaining their clinical skills.
- A full re-credentialing is conducted every three to five years to ensure the doctor is maintaining their skills and qualifications and there have been no significant misdemeanours. A performance review is conducted every year in line with best practice standards for human resource management in any industry. This performance review is to be linked to the full credentialing system.
- The professional development required by the relevant medical college or other relevant authority is currently the benchmark for skills maintenance.
- Scope of practice is defined in detail and applies specifically to each hospital. Approval to perform a particular procedure is given if it is within the capacity of the hospital (size, staff, skills of nursing staff, equipment), and the doctor. The doctor's skills for the procedure and scope of practice need to be verified by an expert in the field, and recognised by the relevant authority.

Conclusion

Credentialing and ongoing performance review of practising doctors is now considered to be an essential part of quality and safety management for the community being served.

This process should have a significant impact on reducing adverse outcomes associated with inpatient and ambulatory care. As audit and risk management activities in health services become better embedded in daily practice and feedback systems improve, peer review will provide medical practitioners with a supportive reflective learning environment.

In addition, the frustration experienced by doctors who are obliged to do more and more paperwork that does not relate to the clinical care of their patients, needs to be assuaged by access to clinical audit and review environments that are stimulating and supportive, and that have positive behavioural change outcomes.

There are obvious gaps that need further consideration before there is certainty that everything is being done to ensure safe medical practice; these have been highlighted by the work of Marie M Bismark et al in their paper on 'Identification of doctors at risk of recurrent complaints' (4). In Australia, for example, employers and health services do not have access to information held by Health Commissioners or medical boards, and so are dependent on self-disclosure from the doctors they are interviewing. Similarly, medical colleges do not have access to this information to enable proper scrutiny and requirement for further training or other actions. Currently, medical colleges in Australia rely on self-reporting by the practitioner.

It is becoming clear that there needs to be further discussion amongst the medical profession about issues of performance during training as well as performance as medical practitioners, and how information that is held about doctors with more than two complaints against them, is managed.

Ideally the profession should lead this process as part of the increased focus on quality and safety in health care. Doctors are more likely comply with and support a process led by their peers than a framework imposed by government administrative bodies.

References

1. Department of Health, Victoria. *Credentialing and Defining the Scope of Clinical Practice*, 2011. http://www.health.vic.gov.au/clinicalengagement/credentialling/toolkit.htm (accessed 18 February 2014).
2. Birrell B. *Too many GPs*. Centre for Population and Urban Research, Monash University, 2013 Mar.
3. Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005 Dec 22; 353(25): 2673-82.
4. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. *BMJ Qual Saf .* Identification of doctors at risk of recurrent complaints: A national study of healthcare complaints in Australia. DOI: 10.1136/bmjqs-2012-001691 (accessed 12 November 2013).
5. *Bundaberg Hospital commission of inquiry: Queensland health initial submission*. Queensland Government: Queensland Health. 2005 May 16.
6. Australian Council on Healthcare Standards. *EQuIPNational Mandatory Actions.* October 2012. http://qualitysafety.bmj.com/site/about/guidelines.xhtml#open (accessed 1 September 2013).

This article is a chapter from the ***WONCA Rural Medical Education Guidebook***.
It is available from www.globalfamilydoctor.com.

Published by:
WONCA Working Party on Rural Practice
World Organization of Family Doctors (WONCA)
12A-05 Chartered Square Building
152 North Sathon Road
Silom, Bangrak
Bangkok 10500
THAILAND

manager@wonca.net

Suggested citation Greacen J. Credentialing and re-certification of rural doctors. In Chater AB, Rourke J, Couper ID, Strasser RP, Reid S (eds.) *WONCA Rural Medical Education Guidebook.* World Organization of Family Doctors (WONCA): WONCA Working Party on Rural Practice, 2014. www.globalfamilydoctor.com (accessed [date]).