To the Executive Officer, AHPRA;

I write with concerns about the Consultation Paper regarding the proposed revised CPD Registration standard and formally wish to note my preference for **Option 1 – Retain the status quo.**

My concerns regarding the proposed changes are as follows:

a) Increased time constraints

While the Consultation Paper, and the previous Final Report of the Medical Board of Australia Expert Advisory Group on Revalidation 2017 state that the aim is not to increase time constraints with CPD changes; this is not the case with my general practitioner colleagues.

Currently, their CPD minimum criteria of 130 points over three years equates to approximately 10-12 hours per year. The proposed requirements of 50 hours a year could therefore increase these hours up to fourfold.

b) Reducing flexibility and choice

The Consultation Paper makes repeated references to increased flexibility in terms of CPD activities. However, this is fundamentally contradicted by the fact that under the new proposals, certain categories of CPD (measuring outcomes and reviewing performance) have become mandatory, while the other category (of educational sessions) has become severely capped. This actually restricts the flexibility of CPD for any given practitioner.

This is especially problematic given the relative lack of resources available for the first two categories. In my college, the Royal Australasian College of Physicians, there is not even a standardised Regular Practice Review document. There is no standardised performance appraisal document. There is no standardised tool for Multi-source feedback (only a link to an external commercial provider which was used in a 2017 trial, and that charges practitioners $450: it is unfeasible that there will be much, if any, uptake of such an unwieldy expensive tool). There are proposed lists of nebulous ideas for audits but the majority of these require big data collection which is beyond the capability of many practitioners: see point e) below.

Conversely, there has over the last few years been significant investment in educational sessions in the form of journal articles, online interactive courses, live video streams, and audio podcasts. These have allowed easy access for practitioners to learn, develop and study from home, especially when geographically isolated. The effort undertaken by the College to provide such robust and stimulating online materials seems to have been in vain if only 12.5 hours of such learning a year is to be recognised per practitioner.

c) Unfairly disadvantaging to certain practitioners

As might be expected, the increased focus on peer-based and patient-based feedback, and outcome measurement, unfairly disadvantages the following groups of practitioners who have to undergo significantly more onerous work to fulfil requirements:

- Those in solo GP or specialist private practice, where outcome measures are not routinely captured and/or there is not the infrastructure to capture outcome data
- Those who are geographically isolated
- Those who work in an infrequent or itinerant locum capacity in various settings, and therefore are not linked to a peer group, or privy to measured outcomes in any one given setting
- Those who work part time, and/or are transitioning into retirement
- Those whose work does not involve regular clinical contact with patients or other clinicians

These doctors will likely have to manufacture peer groups for feedback and discussion, which are likely to be based on artificial relationships of convenience rather than true peer observation and discussion. For example, in the UK there are entire cottage industries of doctors who peer review others who are not attached to a college; they charge exorbitantly but their clients have little choice due to the onerous need for yearly appraisal. There is no professional or personal relationship between these 'peers'- it is but a mercantile exchange to fulfil regulatory requirements. I have personally been a client in this situation. Explaining my career pathway to another doctor I have never worked with, and never will work with, gave me no beneficial insight and cost hundreds of pounds. It simply kept the UK General Medical Council from striking me off the roster.

Peer review and reflection may have benefits, but it should not be forced upon Australian practitioners as a punitive measure with the threat of deregistration. (It will be, despite some platitudes in the Consultation Paper, a threat… as it will be governed by a regulatory body AHPRA, rather than an educational body.)

d) Unfairly advantaging to certain practitioners

Conversely, the following groups of practitioners are significantly, unfairly advantaged

- Those who work in medical administration (and who therefore measure outcomes as part of their routine workload)
- Those who work in academia, and therefore are frequently involved in grant writing, supervision, peer meetings, and outcome measurements simply as part of their routine workload
- Those who are senior enough to hold management or leadership roles in large organisations (and who therefore sit on multiple committees and boards as part of their routine workload)
- Those who work in the medicolegal or incident reporting field

It must be noted that these represent a privileged minority of Australian doctors, who are already formally remunerated for measuring outcomes and reviewing performance. They will unfairly expend minimal extra energy to fulfil these proposed CPD requirements.

e) Paucity of data access, redundancy of data analysis

Many listed ways of measuring outcomes requires access to data sets which are rarely easily accessible to practitioners in large health institutions or regions. Data such as surgical and outpatient waitlist times, bed capacities, patient flow, accreditation standards et cetera are collected by professional managers in such organisations, as the infrastructure and information

technology needed to capture this data are beyond the remit of what any one clinician can achieve. Accessing this data to satisfy CPD hours is difficult for clinicians who are not employed in this capacity, and are often not authorised by the organisation to access such datasets.

Furthermore, there is significant redundancy in having inexperienced clinicians to assess this data, when there are already data professionals hired by health organisations to do this work. Clinicians run the risk of overstepping professional boundaries herein, and duplicating work for no net gain to the health organisation.

f) No guarantees as to the acceptance of logged hours for certain activities

It is unclear how clinicians can prove their documented hours of CPD in measuring outcomes and reviewing performance. Educational activities are far more quantifiable: they generally last for a given number of hours, or have a quantitated number of points assigned to them. Conversely, it is difficult to prove the number of hours spent on a more nebulous process like a multi-source feedback, or a practice audit. This may create significant stress among practitioners as they struggle to prove their logged hours in the face of sceptical auditors.

For example, a clinical audit may appear very small when the data is uploaded on a spreadsheet. However, the small size may not accurately reflect the extended period of time it took the clinician to gain access, extract, log and analyse the data. This is especially the case if, for example, feedback forms are required from patients who are slow to return their forms and require constant chasing; or extended organisational paperwork is needed to access the data in the first place. Therefore any given audit could take one hour, or take dozens of hours, due to these variables. How can clinicians therefore be guaranteed that their logged hours will be received in good faith by auditors, rather than by punitive scepticism?

Furthermore, if an audit is started but cannot be completed for some reason by the end of the CPD year, how will clinicians show proof of their hours, and how will they be guaranteed that such proof will be received in good faith?

h) Advantaging those with lots of active development goals

Much is made in “reviewing performance” of actively setting goals and planning for these. Clinicians who are actively pursuing a large amount of clinical goals are advantaged herein, such as young ambitious doctors with aspirations to climb the professional ladder. They will be able to log long hours of goal planning that will be impressive to CPD auditors.

However, many clinicians are at a stage in their career where they have few active development goals. Some may be heading toward retirement. Others may simply be dealing with personal health or family issues and cannot prioritise aggressive career progression. Others may be burnt out and wish to maintain a stable, low-stakes practice, just keeping abreast of current research. How can such clinicians be guaranteed than their Professional Development Plans, which may be modest and unambitious, will be accepted in good faith by auditors, rather than by punitive scepticism?

i) Advantaging those with high-stakes work and failures

Relatedly, “reviewing performance” advantages those clinicians who undergo difficult, high-stakes work as they will frequently have more complex cases to discuss, more failures to reflect on, higher learning curves and room for growth, and more of a team of peers to log CPD hours with.

While such work is admirable, not every clinician can work in such a high-stakes field. Not everyone’s practice can be shifting and rapidly expanding.

Clinicians who work in more low-risk settings (and whose work is no less important) are unlikely to have many hours of difficult case reflection. Many are content to maintain a stable, low-stakes practice exercising a limited amount of skills than they have long mastered, with minimal complications. They have every right to practice in this way, as long as they do no harm and they benefit the community.

How can such clinicians be guaranteed than their performance reviews and reflections, which may often have no major changes from month to month, will be accepted in good faith by auditors, rather than by punitive scepticism?

j) Unreliability of patient feedback

Patient feedback, on the whole, is proven to be useful at a macroscopic health systems level. However, for individual doctors, seeking patient feedback is onerous and highly subjective.

Of concern, multiple studies have shown systemic biases against doctors of female gender and/or of discordant ethnic backgrounds in patient feedback surveys (see Rogo-Gupta et al, Women's Health Issues 2018, 28:3, Sotto-Santiago et al, Health Equity 2019, 3:1) and, for these subgroups, should be treated cautiously as reflections of practitioner competence or clinical skill.

k) Poor evidence base for change

This overhaul of the CPD system, with the significant potential problems listed above, is being performed without reliable evidence of benefit to patient outcomes (as acknowledged by the authors of the Consultation Paper, reviewing the systemic analysis of Cervero and Gaines). There is no evidence provided as to whether the current CPD systems in Australia are failing our patients, compared to newer models being implemented in New Zealand, Canada and the United Kingdom. Although with some flaws, recent qualitative and quantitative studies by Dale et al (BMC Family Practice 2016; 17(1)) and Gutacker et al (BMC Med 2019, 17**,** 33) suggested the onset of revalidation in the UK NHS was an independent factor in GPs and specialists leaving the service in dissatisfaction.

The Consultation Paper discusses a minority of underperforming doctors at length. However, there is no philosophical correlation drawn between overhauling the CPD program and alleviating the problem of underperforming doctors. Factors discussed such as older doctor age, early detection and information sharing within healthcare systems, and cultural changes actually have nothing to do with individual CPD performance. There is no evidence provided that imposing more onerous CPD programs on all Australian doctors, with significant time and monetary costs to the vast majority, will reduce the minority of underperforming doctors.

To conflate the two issues together in a single consultation paper appears to be ‘begging the question’ without an empirical basis.

Similarly, large amounts of the Consultation Paper discuss establishing CPD Homes outside of the traditional specialist colleges. This is reasonable for the small minority of doctors who wish to perform CPD outside of their college. For specialist physicians, I anecdotally suspect this will be very few, as the college is reasonably well respected and the post-nominal FRACP is an honorific that few will be willing to give up. Making this change in isolation is reasonable. It should not, however, provide an excuse for an overhaul of the entire CPD requirements.

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