The Medical Board is inviting submissions until 14th February and is considering 2 options;

1. Retain the Status Quo.
2 . Strengthen CME.

The main considerations canvassed regarding strengthening CME essentially revolve around the concept of a ‘CME home’, the idea of a ‘CME plan’ and that the proposals will have ‘minimal impact’ on medical practitioners.

They argue that evidence exists that CME can improve practitioner performance, though perhaps not patient outcomes, based on the findings of Expert Advisory Board (EAG) on Revalidation 2017 and the following papers;

R.M. Cervero and J.K. Gaines, ‘The impact of CME on position performance and patient healthcare outcomes: an updated synthesis of systematic reviews’, Journal of continuing education in the health professions, vol. 35, no. 2, 2015, pp. 131-138.

M.K. Robertson, K.E. Umble and R.M. Cervero, ‘Impact studies in continuing education for health professionals: update’, Journal of continuing education in the health professions, vol. 23, no. 3, 2003, pp. 146 -156.

The paper referred to is a North American paper and refers to experiences in North America. The EAG specifically states that no evidence exists in terms of the effect of CME on outcomes in Australia. The Final Report of the AEG on Revalidation in 2017 makes clear that;

‘We need to be able to identify ‘at-risk’ practitioners early; …assess, support and remediate them when possible; and manage any ongoing risk to public safety. Patients have a right to expect this and as a profession, doctors have a responsibility to ensure it. Many recommended activities to strengthen CPD will also help to more effectively identify and manage risk. For example, performance review and outcome measurement through strengthened CPD will constructively identify practitioners’ performance gaps that may otherwise pose risk to patients, but can be addressed with targeted education or professional development. Equally, increased peer review in a standard CPD process will increase engagement and feedback and provide additional support for professionally isolated practitioners.’

But that;

‘International research indicates that about six per cent of medical practitioners are poorly performing at any one time. No Australian research has yet reliably identified how many medical practitioners in Australia fall into this category and future Australia-specific research should ratify this number.’

And that;

‘They have pointed out that although we now know what types of CPD are effective, the highest level of evidence, being the systematic reviews, do not

explain what strategies are most effective, under which conditions, and for what purposes.'

Based upon the Medical Board's own statements, there is a paucity of evidence available on the impact of CME in Australia. Before any changes are to be considered, it is of utmost priority that independent and accurate data is obtained. Without such evidence implementation of proposals may be detrimental to existing operations and it will be impossible to determine into the future, the effectiveness of any changes. In essence the Board's proposal is a shot in the dark, without any knowledge or understanding as to whether Option 2 is truly viable as a consideration.

Consequently the Medical Board's opinion that Option 2 will have 'minimal impact' on medical practitioners cannot be relied upon in good faith, given there is minimal data available for them to make such a claim. In particular, the cost of the creation of 'CME Homes' has not been considered at any point in their proposal document and it seems quite likely that costs will indeed accrue for medical practitioners, which in turn will likely be passed on to patients as increased fees or reduced rates of bulk billing.

Therefore I suggest it is an imperative that proper costings are performed prior to the implementation of any changes and an *'impact report'* should be considered to determine the likely effect of changes on health care costs to patients and consequently the effect on access to health services.

Any proposed changes to continued professional development for medical practitioners must carefully and holistically consider all the consequences in the delivery of health services, including the wider ramifications of affordability and the effect on poorer sections of the community already

experiencing worsening health outcomes. It would be entirely counterproductive to claim improved performance through regulatory processes whilst disenfranchising already vulnerable patients from healthcare because of costing failures and ill-considered policies based upon belief rather than evidence.

Heterogeneity exists within the medical workforce and within the Australian community. It is quite possible that changes that lead to improvements in one arena could undermine progress and achievements in another. It is also essential to appreciate that strategies implemented in healthcare services overseas may fail or be counterproductive when applied in Australia. Whilst the Medical Board has a constitutional obligation to drive evolutionary change within Australian healthcare, it must also be recognised that evolution isn't necessarily beneficial, or indeed that benefits to some can be associated with detriment to others.

Evolution without design or measurement can lead to chaos and it's unclear from the Medical Board's document on the proposed CPD changes what improvements are to be anticipated or indeed how they should be evaluated. Rather it seems to represent a grand statement about the merits of CPD improvement without the mention of any focused objectives and how they would be appraised, other than to say they would be desirable.

The document does reflect on the need for a transition period and this could be of immense value if used to compare existing arrangements with the proposed changes. I would therefore make the following suggestions for consideration and implementation before the establishment of changes in CPD as proposed in the document;

1. A set of agreed key performance indicators acceptable to the medical colleges and the medical board. These measures should also include the impact on costs for delivery of health services and accessibility of healthcare for a variety of patient groups.
2. The proposed changes be implemented as a pilot, so they can be properly and fully evaluated alongside existing arrangements.
3. An agreed period of evaluation to properly appraise the impact of the changes and to develop evolutionary mechanisms for sustainable improvement.