‘Consultation on revised CPD Registration standard’

Dear Medical Board,

Please see below for my feedback on the proposed “Revised CPD Registration standard’. I have provided detailed feedback on most of the questions posed in your CPD document. I am happy for you to publish my comments provided you have de-identified my feedback. I do not wish to be identified in anyway if my comments are to be published.

Lastly I would like to request for further feedback on consultation of such important nature to be single email all medical practitioners for feedback and not embedded amongst other items in a newsletter format. I only found this consultation paper as an item amongst several other items in a newsletter sent to all medical practitioners. I could have easily missed this if I did not open the newsletter email. I wonder how many other would have missed this important consultation because the request for consultation was embedded in a newsletter amongst other items. I believe further consultation on such important nature should not be embedded in a newsletter because we often don’t read the newsletter and delete them. It should be sent in an email for this purpose only, with headings of email clearly stating the purpose of the consultation.

Your sincerely.

[redacted]

…….

General questions

1. Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?

My comments:

The way the report is written is reasonable. However from what I have read there are assumptions and conclusions made by authors of this report I found to be baseless or ill informed:

1. There is a blanket statement made in this report about medical practitioners in current General registrant category that existing CPD requirements are found to be least effective. I found this point of view from medical board unfair and ill informed.

   The exact wording: Under “All other medical practitioners” on page 33, “Mostly, this group of practitioners currently undertake self-directed CPD that was identified by the Expert Advisory Group (EAG) as the least likely to be effective CPD.”

   This board paper failed to recognise there are a wide range of scope of practice performed by medical actioners in the current General registrant category. It can range from medical practitioners who practices exclusively in provision of direct care to patients in emergency departments, general practice, or rural hospitals etc. However the range of practice also

extend to medical practitioners who exclusively practice in non-direct patient contact roles, and provide no direct care to patients. The blanket statement made about current self-directed CPD activities are least effective about all medical practitioners in general registrant category in the board paper is very unfair and indeed misinformed. While it may be true that medial practitioner in General registrant category who work in direct patient contact roles and undertake self-directed CPD can be compared to the CPD activities of their specialist counterpart. Board can not compare like for like the medical practitioners who works exclusively in non-direct patient contact roles to those who works exclusively in direct patient contact roles. For a simple and yet fundamental reason the scope of practice is very different and for one cohort there is no direct care provided to patients.

I fall into the category of medical practitioners who works exclusively in non-direct patient contact roles. I found it quite offensive that board, without knowing the scope of my practice, would see my current CPD effectiveness in the same light as medical practitioners working to provide direct care to patients. One of my roles is primarily about driving business performance through health technologies. There is no direct care provided to patients. why would my current CPD activities be least effective? Where is board drawing that conclusion from? Also since there is no direct care provided why has medical board proposed that I undertake “Measuring outcome” and “Reviewing Performance” CPD activities which is aimed at improving quality of direct care provided to patients, and have no direct relevance to my scope of practice? I would like a formal feedback on this point please.

2. From reading this report I can see a perception being created that these 3 types of proposed CD activities are required to makes sure medical practitioners’ ability to provide direct care to patient is not lowered. There seems to me there is a narrative created that if medical practitioners fall behind in his/her CPD their ability to maintain provision of high quality is impaired. This is far from the truth and the perception of such is very unfair. We are highly trained medical professional and far majority of us are in this profession because we care about our patients and we care for our profession. Yes some of medical practitioner have shown to commit serious misconduct but this is the by far the minority of us. Most of medical practitioners work hard to provide care to our patients. Medical board can not paint all of us with the same brush.
3. Also if there is credible and peer reviewed clinical evidence that if medial practitioner fall behind in their CPD then direct care provided to patient are then compromised, please share that with all of us medical practitioners. Not just single line reference to small print at bottom of the page. The analysis by medical board of such evidence should be opened up for review by all of us and feedback provided. This is important because this is the foundation of medical board’s argument for changing CPD requirement to this complex system of CPD homes and the 3 categories of CPD activities. Analysis of such evidence and how conclusions are reached based on such evidence, and the peer reviewed data should transparent and shared publicly. This certainly was not done in this paper and must be added.
4. There are clear assumptions that impact of these proposed CPD changes will be minor to colleges and medical practitioner will be minor. This assumption and conclusion drawn is certainly misinformed. A perception has been created that there are all positives and no negatives. I have discussed in detailed in my comments to other questions in this document regarding designing and implementing new CPD home, to do it properly will require significant effort. This will require design, consultation with medical practitioners, revision of

design, then implementation, then accreditation. Not to mentioned post implementation ongoing accreditation and compliance efforts. These are simple project management challenges and yet there is no mention of the potential difficulties with these complex issues or how this will be managed and dealt with, under guidance of Ahpra. The authors of this board paper must go back to drawing board and examine the actual impact on colleges to design and implement CPD home while consulting their members along the way. Not to mentioned some of re CPD home will be brand new and never existed before like the colleges. This is even more complex. I have discussed in detail in some of my feedback below.

5. There is the complete lack of recognition of a group of medical practitioners who work exclusively in non-direct patient contact roles. This group of medical practitioners often do not belong to a college. This means a brand new CPD home will need to be set up for this cohort of medical practitioners. Unlike existing colleges this group of medical practitioners do not have existing relationship with the this CPD home, there is no existing mechanism to regularly consult and resolve member's concerns, like colleges have. There is no recognition of this group of medical practitioners at all in this paper and these challenges relating the design and implementing a brand new CPD home for them. Authors for the board paper is clearly unaware of these issues. If they're aware these issues why are they not recognised in the board paper.

2. Is there any content that needs to be changed or deleted in the draft revised standard?

My comments:

The suggested exempted group seem reasonable to me. However I would like to point out, as I have done so throughout my replies and comment in this submission that medical practitioners on the category of non-direct patient contact, and provide no direct care to patients should be exempt from the proposed "Measuring Outcome" and "Reviewing Performance" CPD activities. I have written in a lot of details as to why throughout this submission. Please refer to them. To summary my concerns, the proposed "Measuring Outcome" and "Reviewing Performance" CPD activities have no direct relevant to scope of practice which has no direct patient contact.

3. Is there anything missing that needs to be added to the draft revised standard?

1. this board paper has not sufficiently addressed the wide range of scope of practice for medical practitioners who works exclusively in non-direct patient contact roles. Especially in the case of current general registrants' category of medical practitioners, those who work in non-direct patient contact roles vs. those actually work in direct patient contact roles are being painted in the same light as far as CPD requirements are concerned. For those doctors who work exclusively in non-direct patient contact roles self-directed CPD works. There is no direct care provided to patients, there is no direct patient contact, and there is a wide range of scope of practice. Self-directed CPD the way it is now works for this category of medical practitioners. This must be recognised in this board paper.
2. This paper assumes that setting up CPD homes and post set up requirement on CPD homes are easy and has minimal impact on medical partitioners and colleges. From my perspective this is an ill-informed point of view. The journey of setting up CPD homes should include design, consultation, revision of design, then implementation while continued to address member's concerns, then accreditation and then post implementation compliance which will be ongoing. Having been involved in large number of projects in the past these challenges are anything but easy. To say there will be minimal impact on colleges, other prospective

CPD home and medical practitioners themselves to me is an ill informed and one-sided point of view. This board paper must consider what these challenges are, how will prospective CPD manage them, how can medical practitioners be consulted along the way, who will be bearing the cost of going through all these changes? The cost must also include post implementation compliance requirement which will certainly come at the cost to colleges and other prospective CPD homes. Is medical practitioners asked to bear the cost in the form of higher annual Ahpra fees, or higher college member fees? It is already costing us a lot of money to undertake CPD activities, register with Ahpra and colleges. Are we not going to be asked to pay for these changes Ahpra is proposing? All these process changes, change management cost to person and organisation must be recognised in this board paper. I do not see that here.

5. Who does the proposed registration standard apply to?

a. Should the CPD Registration standard apply to all practitioners except the following groups?

- medical students

- interns in accredited intern training programs

- medical practitioners who have limited registration in the public interest or limited registration for teaching or research (to demonstrate a procedure or participate in a workshop) and who have been granted registration for no more than four weeks

- medical practitioners who are granted an exemption or variation from this standard by the Board in relation to absence from practice of less than 12 months

- medical practitioners with non-practising registration.

My comments:

Yes, they should.

b. Are there any other groups that should be exempt from the registration standard?

My comments:

The suggested exempted group seem reasonable to me. However I would like to int out, as I have done so throughout my replies and comment in this submission that medical practitioners on the category of non-direct patient contact, and provide no direct care to patients should be exempt from the proposed “Measuring Outcome” and “Reviewing Performance” CPD activities. I have written in a lot of details as to why throughout this submission. Please refer to them. To summary my concerns, the proposed “Measuring Outcome” and “Reviewing Performance” CPD activities, according to medical bard is meant to improve outcome of direct care provided to patients. For medical practitioners who work in roles which has no direct patient contact and provide no direct patient care the 2 types of CPD is not relevant, because in non-direct patient contact roles there are no patient being looked after.

Medical practitioners who works exclusively in non-direct patient contact roles should be exempt from the 2 types of CPD. These roles include: teaching, health technology, exclusive management

roles (with no requirement to provide direct care to patients) and many others. I fall into his category, I do not have any direct patient contact to provide direct care to patients. It makes no sense to me at all why Ahpra would suggest that medical practitioners like myself will be required under this proposed CPD requirement must undertake CPD activities to improve direct patient care.

8. International medical graduates

a. Should IMGs be required to complete CPD in addition to or as part of their training program or supervised practice?

My comments:

IMG doctors working in junior doctor roles in public hospitals are already heavily supervised with rigid and well-structured training they are required to go through. Not to mentioned they're required to pass AMC exams as part of their progression towards general registration. I think they should be exempt from the CPD requirements.

IMG doctors working in general practice are normally also well supervised. However because of nature of general practice I am not sure if they will require similar CPD as their generally registered or VR registered GP.

b. If CPD is included as a component of their training program or supervised practice, should IMGs have to comply with the same mix of CPD as other medical practitioners?

My comments:

IMG doctors working in junior doctor roles in public hospitals are already heavily supervised with rigid and well-structured training they are required to go through. Not to mentioned they're required to pass AMC exams as part of their progression towards general registration. I think they should be exempt from the CPD requirements. However if they are required to undertake some CPD, I think educational CPD should suffice.

IMG doctors working in general practice are normally also well supervised. However because of nature of general practice I am not sure if they will require similar CPD as their generally registered or VR registered GP. However if they are required to undertake some CPD, I think educational CPD will be required. I am not certain of the other 2 types of CPD.

c. Should IMGs have to record what CPD they are doing or is completion of the program requirements or supervised practice plan sufficient to comply with the standard?

My comments:

IMG doctors working in junior doctor roles in public hospitals are already heavily supervised with rigid and well-structured training they are required to go through. Not to mentioned they're required to pass AMC exams as par of their progression towards general registration. I think they should be exempt from the CPD requirements. However if they are required to undertake some CPD, I think educational CPD should suffice. In this case they should be able to record the educational CPD activities as required of them.

IMG doctors working in general practice are normally also well supervised. However because of nature of general practice I am not sure if they will require similar CPD as their generally registered or VR registered GP. However if they are required to undertake some CPD, I think educational CPD

will be required. I am not certain of the other 2 types of CPD. Whatever CPD activities they undertake it should not be difficult to record them.

9. Exemptions

a. Should exemptions be granted in relation to absence from practice of less than 12 months for parental leave, in addition to serious illness, bereavement or exceptional circumstances?

My comments:

This seem reasonable to me. I agree.

b. Is 12 months an appropriate threshold?

My comments:

I would suggest this extend to 18 months. It is not uncommon for parental leave to go past 12 months, I have known personally examples of that. Also nature of serious illness is such that it can take longer than expected, it is unpredictable. So is bereavement and other exceptional circumstance. I would suggest that Ahpra allow for a longer duration of 18 month to accommodate for such circumstances, some of which can be tragic and unfortunate. Our colleagues going through these circumstances deserve a longer period than just 12 months.

c. Should CPD homes grant these exemptions or should the Board?

My comments:

CPD home can grant it, however there must be a pathway to appeal the decision not to grant it to medical board. I have mentioned there must be oversight to what CPD homes do, the decisions they make and the corrective actions they take. CPD homes can not be allowed to be a law onto themselves, they must be accountable in the way they look after medical practitioner's CPD requirement. Board need to recognise that with these new CPD requirement it will be much more complex than before to stay on top of CPD. It is not true these new requirement will have minimal impact on all stakeholder, including medical practitioners, as stated in this report. At the same time CPD issues will result in inability to renew our registration. These changes are serious for all medical practitioners. Some more so than others.

Unlike what board paper suggest this will require much more effort from medical practitioners. Therefore board must makes sure CPD is there to support medical practitioners, ensure medical practitioner has a voice in the CPD home they belong to and are consulted on all changes proposed to that CPD home. Board must ensure this is built into the operational process of CPD home. there must also be appeals body within board to manage companies about the CPD home form medical practitioners to ensure accountability on CPD homes.

It is very important to recognise that CPD home is not part of the board, and yet wield immense power to determine if medical practitioner's registration will be renewed or not. This power must be held accountable. The accountabilities must be built into the audit process and requirement on each CPD home, and there must be appeal process managed by medical board too.

10. Practitioners with more than one scope of practice or more than one specialty

a. Do you agree with the Board's proposal that medical practitioners with more than one scope of practice or specialty are required to complete CPD for each of their scopes of practice/specialty and where possible this should occur within one CPD home? Do you have alternative suggestions?

My comments:

The key question for me are:

1. How will one CPD home accommodate medical practitioners with multiple scope pf practice? How will this work in actual practice. This may seem like a good idea but without taking a look at the actual details of how this looks like in practice it is hard to determine.
2. CPD home is a new entity prosed by Ahpra which has never existed before. As I mentioned above it is not a simple process of creating a new CPD home. Even with colleges who already representing specialists in their field pf practice it will take a lot of effort to get CPD home up and running-from design to implementation to accreditation etc. I am very concerned about brand new CPD home to represent medical practitioners with multiple scope of practice. How will this occur? What measure can Ahpra take to ensure medical practitioners' concerns are addressed all along the way as all CPD homes are set up and CPD framework implemented?
3. I agree in principle where possible CPD should be completed in one CPD home. This might be true of specialist working in their field of specialty and also do teaching or management work in the same field of speciality. This can be easily managed within the same CPD home. However there are other medical practitioners like myself who works multiple different jobs, all of which are non-direct patient contact in nature. I work in health technology and teaching, I also plan to do locum (100% management) work in future whenever possible. This is quite a wide range of work I do. In my case how would my CPD activities be managed within one CPD home?
4. In cases similar to mine, where all my roles are non-direct patient contact in nature, if medical practitioners in this category like me is not required to undergo "Measuring Outcome" or "Reviewing Performance" CPD activities and only Educational activities are required, then I can see keeping all CPD activities in one CPD home much more workable.

11. CPD required

a. Are the types and amounts of CPD requirements clear and relevant?

Comments:

- The document is clear on the 3 types of CPD being proposed, however I do not believe the types of CPD activities are all relevant to scope of practice for the category of medical practitioner who work in non-direct patient contact roles. I also do not believe not all 3 types of CPD activities proposed are appropriate for clinicians in their scope of practice. My specific reason provided as follows.
- On the point of "Measuring Outcome" CPD activities proposed for specialist clinicians: measuring outcome of individual patients treated by specialists themselves can be a complex task. Firstly, what bench mark is proposed to be deployed for measuring outcome

for certain clinical presentation or clinical condition? Is there peer reviewed guidelines or protocols which can be used as bench mark? Would they be appropriate for the presentation or condition under review for that clinician at the time? Will "Measuring Outcome" activities for that particular clinical presentation or conditions take into consideration of nuances of that individual patient's presentation or condition? Because for the same main complaint or condition they can have wide range of spectrum of presentations.

Therefore my question for medical board are:

1. "Measuring Outcome" can be a complex task, what methods and approach does medical board propose to deal with such complexity? So the process of reviewing individual patient's outcome of management is fair and clinician's right to due process is preserved?
2. How do you manage the privacy and confidentiality issues, because patient information used in reviewing outcome and treatment performance are not used for care of patients. Will patient consent be required? Where will this information be stored because they ate confidential information? Will they have to comply with privacy legislation? Who is going to bear the burden of the storage cost to make sure this information are securely and privately stored?
3. What processes and policies will Ahpra set up to manage information gathered when reviewing doctors treatment performance, or measuring doctor's care outcome? This is not a process of investigation into an incidence or complaint. This is a professional development process for professional development purpose. How do we ensure doctors' right to privace and confidentiality is upheld? That information gathered can not be used for purposed other than professional development purposes only?
4. Specialist working in various environment often has to deal with office politics, interpersonal conflicts, gender/age/race bias etc. For example in public hospitals of large or small clinical departments, these are not uncommon issues individual clinicians need to deal with as they arise. I personally had to deal with my fair shares of them over the years. My questions for medical board is how does board propose that "Measuring Outcome" and "Reviewing Performance" activities will not be used and abused by underlying and difficult contextual issues in the work environment such as office politics, interpersonal conflicts, gender/age/race bias etc?

- On the point of "Reviewing Performance" CPD activities proposed for specialist clinicians: Performance for specialists in their work place is often not about clinical outcome of the treatment and diagnostic decision they make. It is often about business targets and administrative activities. A good example here is the emergency wait time targets and elective surgery wait time targets. There are many more example of this nature.

  Therefore my question for medical board here are:

  1. "Reviewing Performance" can be largely not about diagnose and treatment of clinicians' patients. How does board ensure that "Performance Appraisal" and "Multi-sources Feedback" as CDP activities will not be used by employers to intimidate clinicians, when renewal of clinicians' annual Ahpra registration depends on this new CPD requirement.
  2. Specialist working in various environment often has to deal with office politics, interpersonal conflicts, gender/age/race bias etc. For example in public hospitals of large or

small clinical departments, these are not uncommon issues individual clinicians need to deal with as they arise. I personally had to deal with my fair shares of it over the years. My questions for medical board is how does board propose that "Reviewing Performance" activities will not be used and abused by underlying and difficult contextual issues in the work environment such as office politics, interpersonal conflicts, gender/age/race bias etc? Clear examples here include the potential for abuse of "Performance Appraisal" and "Multi-sources Feedback" by employers.

- On the point of "Measuring Outcome" and "Reviewing Performance" CPD activities proposed for General registrants:
  The scope of practice of General registrants can vary greatly. Some works in clinical departments as senior medial officers, career medial officers etc. in public or private hospitals, some works in general practice as non-VR GP. Others work in positions which has no direct patient contact such as teaching positions (Universities or other private facilities), health technology roles as medical advisors or medical leads, Pharmaceutical roles as medical advisors and medial directors etc. Others works in 100% management positions in public or private health facilities such as Director of Medical Services, Executive Directors, COO, CEO etc. There are many other roles that general registrants work in including medical officer for Red Cross blood transfusion, pre-employment medial screening only work where people present for screening are not patients, they are not there for medical treatment or diagnosis, they are there to be assessed on whether or not they're medically suitable for the position they have applied for. They are there because employer requires them to do so.

  My question for the board is:

  1. For General registrants working in positions with direct patient contact to provide diagnosis and treatment, such as senior medial officers, career medial officers etc. in public or private hospitals, some work in general practice as non-VR GP. My question for the board is same as specialist mentioned above, see question 1 and 2 for specialist comments above.
  2. For General registrants work in positions which has no direct patient contact such as teaching positions (Universities or other facilities), health technology roles as medical advisors or medical leads, Pharmaceutical roles as medical advisors where there is no direct involvement in clinical trials or patient research etc. My question for the board is, since there is no direct patient contact, there is no diagnostic and treatment decision taken at all, why are these clinicians required to undertake "Measuring Outcome" and "Reviewing Performance" CPD activities? These CPD activities are not relevant to their scope of practice. Myself for example, I have held a number these roles over the years and still work in some of them now. "Measuring Outcome" and "Reviewing Performance" has no relevance to what I do if my role is primarily about driving business performance through health technologies. Similarly if I teach basic clinical skills for to students at medical schools. There is no direct patient contact. Therefore there is no diagnostic or treatment outcome to measure, there is no "Reviewing Performance" in treatment of diagnostic decision taken for patients. These CPD activities are not relevant to these types of non-direct patient contact roles.
  3. For General registrants work in 100% management positions in public or private health facilities such as Director of Medical Services, Executive Directors, COO, CEO etc. There are no direct patient contact in these role to provide diagnostic nor treatment decisions. For 100% management role there are no expectation to see patients, nor to provide

actual clinical advice or make direct diagnostic or treatment decision for patients. There is no direct care provided to patients. There is no "Outcome" to measure, nor "Performance" to review when it comes to care and treatment provided to individual patients, because there is no patients directly under direct care.

Moreover the nature of these management positions meant any medical practitioner working in these positions, specialist or general registrant will very often have to deal with office politics, interpersonal conflicts, gender/age/race bias etc. For example in public hospitals of large or small, these are not uncommon issues individual medical managers need to deal with as they arise. I personally had to deal with my fair shares of it over the years and I have worked in these management roles. My questions for medical board is how does board propose that "Measuring Outcome" and "Reviewing Performance" activities will not be used and abused by underlying and difficult to see contextual issues in the work environment such as office politics, interpersonal conflicts, gender/age/race bias etc?

I specifically point to CPD activities listed in this board paper like "Performance Appraisal" and "Multisource Feedback" at work place. For these management roles, how does board ensure that "Performance Appraisal" and "Multi-sources Feedback" as CPD activities are not being used by employers to intimidate clinicians or even force clinicians to leave their job, when renewal of clinicians' annual Ahpra registration depends on these proposed CPD requirement?

4. For General registrants work in pre-employment medial screening only, where people present for screening are not patients, they are not there for medical treatment or diagnosis. They are there to be assessed on whether or not they're medically fit to work in the jobs they have applied for. They are there because employer requires them to do so. The assessment of medical fit or not for the job applicants applied is very often determined by guidelines companies publish themselves. These guidelines are often not peer reviewed, not always based on evidence. My question for the board is if the people seen by medical practitioners in this category are not patients, they are there because employer told them to be there, they're there to go through a general and basic screening process to determine medical fitness for the jobs they applied for. The guidelines used are often not evidence based, nor peer reviewed. These are not patients, there is no direct patient contact, there is no treatment or diagnosis provide directly to patients. Then my question to medical board is what "Outcome" is Ahpra proposed to measure? And what "Performance" is Ahpra propose to review? Please elaborate in detail.

b. Should all practitioners, including those in roles that do not include direct patient contact, be required to undertake activities focussed on measuring outcomes as well as activities focussed on reviewing performance and educational activities?

My comments:

I certainly do not feel that medical practitioners who are not working in roles with direct patient contact should be required to undertake CPD activities in "Measuring Outcome" and "Reviewing Performance" which are specifically related to direct provision of care to patient. Such roles are not involved in direct patients contact and not providing direct care to patients.

“Educational Activities” can and should remain. Medical practitioner in such roles can continue to develop themselves through education to further develop ourselves professionally in such roles. Medical practitioners themselves should determine the type of relevant educational activities they should take to further their career and profession, rather than being dictated by other who does not understand such roles.

I have already mentioned a list of such roles which does not provide direct care to patients above. I would like to mention here again because it is important that board understand that medical practitioners work in wide range of role, not all of us work in roles provide direct medical care to patients. I did not see mentioned nor exploration of the types of roles medical practitioner like myself who are working in such non direct patient contact roles in board document. Please read through the following again to understand the types of the roles I mentioned, and how these roles have no direct patient contact at all to provide care. “Measuring Outcome” and “Reviewing Performance” CPD activities are not relevant to such roles because such roles do not provide direct medical care to patients.

1. For General registrants or any other medical practitioners working in positions which has no direct patient contact such as teaching positions (Universities or other facilities), health technology roles as medical advisors or medical leads, Pharmaceutical roles as medical advisors where there is no director involvement in clinical trials or patient research etc. There is no direct patient contact, there is no diagnostic and treatment decision taken at all by medical practitioners in this category. Why are these clinicians required to undertake “Measuring Outcome” and “Reviewing Performance” CPD activities? These 2 types of CPD activities according to this document are designed to improve patient outcome. They are not relevant to the scope of practice of medical practitioners in this category with no direct patient contact. I have held a number these roles over the years and still work in some of them now. “Measuring Outcome” and “Reviewing Performance” has no relevance to what I do if my role is primarily about driving business performance through health technologies. Similarly if I teach basic clinical skills for to students at medical schools. There is no direct patient contact. Therefore there is no diagnostic or treatment outcome to measure, there is no “Reviewing Performance” in treatment of diagnostic decision taken for patients, because I do not provide direct care to patients in these roles. These 2 types of CPD activities are not relevant to these types of non-direct patient contact roles.
2. For General registrants or any other medical practitioners who work in 100% management positions in public or private health facilities such as Director of Medical Services, Executive Directors, COO, CEO etc. There is no direct patient contact in these roles to provide diagnostic nor treatment decisions. For 100% management role there are no expectation to see patients, nor to provide actual clinical advice or make diagnostic or treatment decision for patients. There is no direct care provided to patients. There is no “Outcome” to measure, nor “Performance” to review when it comes to individual patients under our care, because there is no patients directly under our care.

   Moreover the nature of these management positions meant medical practitioners working in these positions, specialist or general registrant, will very often have to deal with office politics, interpersonal conflicts, gender/age/race bias etc. For example in public hospitals of large or small, these are not uncommon issues individual medical managers need to deal with as they arise. I personally had to deal with my fair shares of

it over the years. My questions for medical board is how does board propose that "Measuring Outcome" and "Reviewing Performance" activities will not be used and abused by underlying and difficult to see contextual issues in the work environment such as office politics, interpersonal conflicts, gender/age/race bias etc?

I specifically point to CPD activities listed in this board paper like "Performance Appraisal" and "Multisource Feedback" at work place. For these management roles, how does board ensure that "Performance Appraisal" and "Multi-sources Feedback" as CDP activities are not being used by employers to intimidate medical practitioners in these roles, or even force clinicians to leave their jobs, when renewal of medical practitioners'' annual Ahpra registration depends on this new CPD requirement?

c. If practitioners in roles that do not include direct patient contact are exempted from doing some of the types of CPD, how would the Board and/or CPD homes identify which roles/scopes of practice should be exempt and which activities they would be exempt from?

My comments:

I would suggest the following:

1. Medical practitioners working in non-direct patient contact roles do not require to undertake any "Measuring Outcome", nor "Reviewing Performance" types of CPD activities, because they are not relevant to our scope of practice and there is no direct care provided to patients. For detailed explanation please refer to the points I made above.

   This means medical practitioners in this category will only be required to undertake "Educational" CPD type of activities.
2. Making the definition clear about these roles. The definition decides who falls into this category and who does not. The definition should state these are the roles which does not require direct patient contact, and does not provide direct care to patients. The definition should be concise and clear because it should not be complicated. If you do not have direct contact with patients and do not provide direct care, then you fall in this category. Board can provide some examples here too. I have given some of the examples above.
3. After medical practitioners determining if they fall into this category, then it should be the matter of self-declaring that a medical practitioner fall into this category. This process should be made as easy as possible. I would suggest this should be a simple process of ticking a box on a webpage to make such declaration. Board can make it clear that false declarations can result in removal of medical registration with Ahpra. The risk of deliberate wrongful declarations I believe would be very low because there is no reason to lie about our CPD activities, we all have to do it anyway regardless of the scope of the work we do. More importantly there must be an element of trust, we are highly trained medical professionals who pride ourselves in ethical and professional behaviour. We should be trusted to self-declare if we fall into this category.
4. Comments on using possible use job descriptions rather than just self-declare: it is not uncommon for job description to change for the same position over a period of time for such roles. This often occur when there are additional requirements on the job, or when organisation or units medical practitioners work at undergo restructure. Documenting such change of job function is not often well done, or not done at all. This can make existing job description document outdated. Using outdated document to prove one's job falls into this non direct contact category is not appropriate. Again referring back to my point above, why

would we need to prove that we fall into this category? Self-declaration should suffice. I have experienced such issues several times while working in these non-patients contact roles where change in job description is not updated in the existing job description document. This is not uncommon.

The other example is we may not have a job description at all. For some of teaching roles I had I was not given a job description where I taught for several years.

5. Comments on using letters form employers rather than just self-declare: I am concerned about involving employers to provide a latter to state that medical practitioners fall into non direct patient contact category. This will mean medical practitioners will need to go to our line manager to ask for such letter and the line managers are under no obligation to issue them. Also if line managers are uncertain about the reason for this letter they will likely to escalate the request for such letter to their superiors. This can certainly add to the burden these new and proposed CPD activities in individual practitioner. This is because the speed at which the letter can be issued will very likely depend on working relationship between the practitioner and their line manager. If the relationship is good, this might be an easy task. If the working relationship is poor, this can be a difficult process with multiple follow up efforts to chase up on issuance of the letter. Imagine if you are put in this position by medical board to chase up this letter with you line manager who you have a poor working relationship due to issues such as bullying etc. what a difficult situation this is for the medical practitioner, asking for the letter to be typed out and signed by this person who has been bullying you, essentially the person has more leverage on you because of what you are required to do by Ahpra. This can have the potential to cause all sort of ramifications for the job the medical practitioner has and a massive burden for the medial practitioner in circumstances like this.
6. Medical practitioners who locums regularly in non-direct patient contact roles: this include locums regularly in director of medical services or similar roles where the roles are 100% management and no direct patient contact required. The duration of these locum roles can vary between 2 weeks to 1 year or longer, in the same locum role. For locums in these roles who stays on for few weeks to few months and work in multiple roles in various locations. The short-term nature and fluidity of such locum roles means it will be difficult to ask for formal letters or obtain job description. In addition, all difficulties mentioned above also applies to locum medical practitioners in this category with no direct patient contact.

There is no reason not to accept self-declaration that a medical practitioner falls into this category of non-direct patient contact. There should be a degree of trust and self-declaration should suffice.

12. CPD homes

a. Is the requirement for all practitioners to participate in the CPD program of an accredited CPD home clear and workable?

My comments:

1. CPD home may work for some of medical practitioner but it may not work for others. Specialists working their field of practice the difficulties experienced with CPD home might be lower. They already belong to a college, they work in a well define scope of practice in that clinical specialty. They have a long-standing professional relationship with their college. There are existing mechanisms in place to listen and address their concerns. CPD home

might be workable here, provided medical practitioners are well consulted and their concerns addressed by both medical board and college as the process of design and implementation of a new CPD program moves forward.

2. For medical practitioners who work on non-direct patient contact roles is a very different story. The scope of practice can vary greatly, and there is no direct patient contact to provide direct care to patient. Therefore, how does medical board propose to establish a brand new CPD home for these group of medical practitioners, which can serve the same function as college for the specialists, with mechanisms to listen to practitioners' concerns, take feedback, open for debate and consultation and change decision which concerns members of that CPD home. This has not been explained at all in the board CPD document. Please can you provide answers to my questions here?

   For this category of medical practitioners, these CPD homes will be brand-new organisations which medical practitioner in this category will have no exposure to, and catered for a purpose which is not suitable for the scope of practice. This is because the scope pf practice can vary widely from one practitioner to another, and there is no direct patient care involved.

   I believe CPD home is not suitable for this group of medical practitioners and I have a lot of concerns about how this will cause all kinds unnecessary burden on medical practitioner in this category to undertake all 3 types of proposed CPD activities. I am also deeply concerned about the proposed CPD actives in category of "Measuring Outcome" and "Reviewing Performance" which according to this document are meant to improve direct care provided to patients. This is certainly not relevant to this category of medical practitioners.

3. There should be a body within Aphra to manage complaints medical practitioner has in regard to their CPD home as well as concerns over CPD activities. It will make CPD home much more workable by making it accountable. CPD home is not law onto themselves, they must be accountable to their member, as well as medical board. Concrete processes musty eb set up to allow complaints form medical practitioners to be heard, and then managed by medical board. The absence of which is not accountable, nor transparent.

b. Are the principles for CPD homes helpful, clear, relevant and workable?

<u>My comments:</u>

1. CPD homes are new entities proposed by medical board, it has never existed before. Medical board through this document has expressed that colleges are already doing a lot of the proposed functioned of CPD homes and therefore there should not be additional burden to medical practitioners. May I point out some of the flaws with this logic:

- As with design and implementation of new organisations, CPD home will require substantial effort from colleges and other prospective CPD home to design and then implement the model of a CPD home which suitable for their members. On top of that they will need comply and then apply for accreditation to be a CPD home. After they are approved to be a CPD home they will still need to continue to comply with auditing and reporting requirement by Ahpra. These are massive changes required of the colleges and other prospective CPD homes. We must be clear about that.

  Therefore my question is:

1. How long will it reasonably take to work through these issues and manage change appropriately without compromising medical practitioners' rights to provide input and be heard throughout all process of designing, implementing and accrediting individual CPD homes?
2. What are the costs involved to design, consult, revised, and then implement individual CPD homes? What about cost of accreditation? And then the cost of compliance effort which will be ongoing? Who will bear the cost? Is Ahpra going to fund these costs since these are suggestion brought up by Ahpra? Or is this going to be borne by us the medical practitioners having to pay for our college to carry them out? College member already pay annual fees, does this mean there will be additional fees for CPD homes? Has this been thought through? Can you provide answers here?

Bearing in mind "workable" is a fluid term. What may be deemed workable by Ahpra is not always workable for the cohort of medical practitioners, or colleges or other prospective CPD homes. Ultimately the question of CPD home is workable or not depends on:

- Category of medical practitioners- those with direct contact with patients to provide direct care to patient, vs. non direct contact with patients etc. CPD home might be workable functionally for one group but may not be workable in another.
- The process of design, consultation, revision, implementation, accreditation and compliance of CPD homes. Workable or not here depends on medical practitioners' involvement throughout the entire process, with our concerns heard throughout the entire process and our concerns addressed.
- Cost: who will bear the cost of going through all these processes mentioned in the point above? Imagine medical practitioner are require to bear the cost of these proposed measures and then cost is likely to be substantial. That will be extremely unfair. Ahpra is suggesting this, Aphra should pay for any additional cost. That's only fair.
- There should be a body within Aphra to examine complaints medical practitioner has in regard to their CPD home as well as concerns over CPD activities. It will make CPD home much more workable by making it accountable. CPD home is not law onto themselves, they must be accountable to their member, as well as medical board. Concrete processes must be set up to allow complaints from medical practitioners to be heard, and then managed by medical board. The absence of which is not accountable, nor transparent.

c. Should the reporting of compliance be made by CPD homes on an annual basis or on another frequency?

My comments:

1. I believe the reporting requirement should not be more frequent than annually. The more frequent the compliance reporting, the more likely medical practitioners will be required to report on their CPD activities. One of the key statements in this document is CPD homes are not meant to increase burden for individual medical practitioners. Doing it more frequent than annually will very likely cause significant burdened on medical practitioners. Also what is the reason for compliance reporting at 6 months rather than annually? What is Ahpra worried about which needs to be addressed with 6 monthly reporting? Can you elaborate?

d. Is six months after the year's end feasible for CPD homes to provide a report to the Board on the compliance of participants with their CPD program(s)?

My comments:

1. I believe the reporting requirement should not be more frequent than annually. The more frequent the compliance reporting, the more likely medical practitioners will be required to report on their CPD activities. One of the key statements in this document is CPD homes are not meant to increase burden for individual medical practitioners. Doing it more frequent than annually will very cause significant burdened on medical practitioners. Also what is the reason for compliance reporting at 6 months rather than annually? What is Ahpra worried about which needs to be addressed with 6 monthly reporting? Pleas clarify?
2. Therefore as long as frequency is not more than annually, how soon after year's end the reporting is done is not a key issue in my opinion.

e. Should the required minimum number of audits CPD homes must conduct each year be set at five percent or some other percentage?

My comments:

1. Conducting audits will certainly require resources, in additional what CPD homes will be doing as part of their functions. The larger the percentage of audits, the more expensive it is. Also there should be some trust that we as medical practitioners will comply with our CPD requirements. What's is the logic of constantly look over medical practitioners' shoulders through audits, and reporting?
2. I do not believe the audit % should be larger than 5% annually of the members within that CPD home. 2-3% is what I would suggest, for the trust factors and the cost factors.

f. What would be the appropriate action for CPD homes to take if participants failed to meet their program requirements?

My comments:

1. There can be numerous reasons why a medical practitioner's CPD activities are behind. It can be due to personal circumstances, health issues, stressors in life, family issues, work issues and many more. Just because a medical practitioner is behind in his/her CPD activities it does not mean they are not competent clinicians. Therefore if a medical practitioner is discovered to be behind on CPD activities CPD home should collegially discuss this with the medical practitioner, find out why, and work with medical practitioner to get more CPD done within a mutually agreed and reasonable time frame.

   If a medical practitioner is under review by Ahpra due to complaints etc. it will be a different scenario. In this case it will also depends on what the concerns is about the medical practitioner. Concerns over direct care provided to patients will be very diffident to attitude complaints. CPD home and Ahpra will then take into consideration the type of complaints and determine if a more rapid progressions to above CPD activities is required.
2. For medical practitioners working in non direct patient contact roles this falling behind in CPD activities has no consequence to actual quality of patient care, because there is no direct patient care involved, no direct care provided. Same principle and process should apply for when falling behind occurs. Bearing mind there is no direct patientcare involved. The medical practitioner's capacity to work in their non direct patient contact roles is not diminished because he/she is falling behind in their CPD activities.

13. High level requirements for CPD programs

Should the high-level requirements for CPD in each scope of practice be set by the relevant specialist colleges?

My comments:

1. Yes, this should be set by colleges for specialists and general registrants working in that scope of practice. However, I would like point out one area which board must take care in. there are still good and competent senior general registrants without college qualifications working in across a range of specialities like emergency medicine and general practice. as it is they do not belong to a college, and they are not fellow of that college. They should be allowed to continue to work in that position, even if they are not fellow of that college. However the difficulty is that are they required undertake the same CPD activities as college fellows? Even if they are not fellow themselves?

   Also there are known pressure to replace these non-fellow senior clinicians with fellows available to work in these role by employers. This is uncommon. These new CPD requirement s can not be used as a tool to remove these non fellows from these senior clinical positions. How do you propose to do so?

14. Transition arrangements

a. What is a reasonable period to enable transition to the new arrangements?

My comments:

1. This document is primarily high-level suggestions of requirements by medical board. It will need to go through detailed design, consultation, design revision and then implementation processes by individual colleges, and any other organisation applying to be CPD homes. Bearing in mind the medical practitioners in general registrant category not uncommonly work in roles with non-direct patient contact. For these medical practitioners the scope of work they perform may not be relevant to the existing colleges, and they are not represented by the colleges. This means whichever CPD home they end up belonging to may very well be a new one which they had no exposure it before is a very different scenarios for specialist who already belong to a college, which will likely be their CPD home. This is not new to the specialists, the processes are not new, they are existing mechanism for feedback and sounds alarms on issues the specialists are concerned with. These mechanisms need to be built up with these new CPD homes, so will the relationship. Medical practitioners in general registrant category must also play a role being consulted and feedback to the new CPD home in their design and implementation of the new CPD framework published by the board.
2. For medical practitioners in the current general registrant category who work in non-direct patient contact roles: as mentioned above the CPD home they will need to belong to will likely be a new one which they had not had exposure to before. Also medical practitioners must have the confidence that the new CPD home, or homes can cater for the wide range of scope of practice in this category of medical practitioners. Unless medical board is proposing one new CPD home for every scope of practice, it will mean a small number of CPD homes is

needed to cater for wide range of practices for medical practitioner in the non-direct patient contact category. Extra care must be taken to ensure this one, or few CPD homes understand the scope pf practices these medical practitioners are in, the CPD homes are relevant to their scope of practice, there are adequate feedback mechanisms for any issues throughput the design, consultation and implementation process, and continue to be so post implementation. Medical practitioner sin general registrant category must not be disentangled in anyway when compared to their specialist counterpart.

3. There should be a body within Aphra to examine complaints medical practitioner has in regard to their CPD home as well as concerns over CPD activities. CPD home is not law onto themselves, they must be accountable to their member, as well as medical board. Concrete processes musty eb set up to allow complaints form medical practitioners to be heard, and then managed by medical board. The absence of which is not accountable, nor transparent.
4. Suggested transition period: based on an accountable and transparent processes mentioned above for all medical practitioners- specialist or general registrants, and the wide ranging and complexity of issues mentioned above. There should be at least 2 years allowed by medical board, after Ahpra has published the new CPD framework, for existing colleges to go through a well-considered process to design, consultation, revision of design, implantation and then apply for accreditation to become CPD home representing their members.

   As for general registrant practising in non-direct patient contact role there should be at least 3 years allowed for the same process. This is 3 years after Ahpra has published the new CPD framework. Bearing in mind the medical practitioners in this category they're not represented by existing colleges to look after their CPD. Entire new process as well as structures and mechanism must be set up to look after medical practitioner's CDP needs and requirement in this category.

   Additional point to note Ahpra must also set up the body within Ahpra with concrete process to address medical practitioner's complaints and concerns regarding their CPD home or their CPD activities. This will take time too.
5. Comments on what should occur after this round of consultation:
   This medical board CPD document is not a framework, it is high-level suggestions of CPD requirements for consultation by all medical practitioners. Medical board should take all feedback on questions this document raised, revised accordingly and publish the revised CPD requirement document for further consultations. This document should contain more concrete requirements having taken into consideration all comments and feedback. This second round of feedback should then lead to publishing of frame work documents for consultation with colleges, other prospective CPD homes and all medical practitioners. The Framework document should not be only consulted with colleges and prospective CPD homes. We as medical practitioner have the right to see what medical board is proposing for colleges and other CPD homes to do to design and implement the proposed new CPD programme. We need to be able to feedback on that too. We are as much of stakeholder as colleges and other prospective CPD homes are.
6. My own personal view on general registrant in non-direct patient contact roles:
   I am a general registrant working in these non-direct patient contact roles. I have no direct contact with patients, I do not provide direct care to patients. I worked in a number of such roles currently and in the past. I truly do not see why I must be required to undertake "Measuring Outcome" and "Reviewing Performance" CPD activities, because according to this medical board document these activities are designed to improve direct care provided

to patients. They have no relevance to my scope of practice as I do not provide direct care to patients. These 2 types of proposed CPD activities will certainly create significant burden to organise and look for these types of CPD activities which are irrelevant to my scope of practice. it makes no sense to me at all that medical practitioners in this category will be required to undertake “Measuring Outcome” and “Reviewing Performance” CPD activities. It is distressing to even think about it. It seems to me that that authors of this document do not fully understand there are a wide range of scope of non-direct patients contact roles, and it is unfair to require medical practitioners in such roles to undertake CPD activities aimed at improving direct care provide to patients.