ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Medical Board of Australia
Draft revised *Registration standard:*
Continuing professional development

Date **14 February 2020**

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EXECUTIVE SUMMARY

Established in 1927, the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The College is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees and international medical graduates.

RACS supports the medical board in the review of the registration standard for CPD and is committed to working in partnership to develop robust standards for surgeons in Australia. RACS response to each question is provided in the attached report, however RACS supports

1. all medical practitioners being aligned with a CPD provider and supports accredited medical colleges providing their CPD programs. RACS believes that the specialist medical colleges are best placed to understand the needs of their trainees and Fellows, as well as creating appropriate training programs, support mechanisms, and developing and implementing standards.

2. the inclusion of exemptions from CPD for those on maternity leave and supports the standard being further expanded to include those on paternity or adoption leave.

3. the requirement for participation in CPD that aligns with scope(s) of practice. RACS would however like to see further clarification of this standard as the description is currently ambiguous

INTRODUCTION

The Royal Australasian College of Surgeons (RACS) is the leader in surgical standards, professionalism and education in Australia and New Zealand. Our Fellows actively demonstrate their enduring commitment to lifelong learning and Continuing Professional Development (CPD), which is evident in participation and compliance rates of 100% year on year. The on-going delivery of our CPD Program to Fellows is also strongly valued and recognised as one of the core services offered to them by RACS. With strong rates of participation and compliance amongst our Fellows and non-FRACS peers, RACS is well position to continue to lead the development of standards, programs and services to support surgeons in maintaining their CPD.

RACS commends the Medical Board of Australia (MBA) in its open and transparent review of the CPD Standard. We are broadly supportive of the changes proposed and welcome improvements that have an emphasis on the patient and community. Our responses to the questions posed in the consultation paper are outlined below including aspect where we feel improvements could be made to the draft standards.

RESPONSE

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

The content and structure of the draft CPD registration standard is generally clear and relevant. RACS does not hold any specific concerns about the existing CPD standard being unworkable, and while we can see no obvious or immediate impediments in this draft we are conscious that it is often in the implementation of a standard where challenges arise.

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

RACS would support the following changes to strengthen the standard:

1. RACS supports all medical practitioners being affiliated with a CPD Program aligned with their specialist medical college/s and linked to their scope of practice. We do not support generic ‘CPD Homes’.

2. Patient-centred care is central to on-going education undertaken by medical specialists. While RACS firmly believes that specialist medical colleges are best placed to develop programs and education for their specialty groups, we note the importance of working in partnership with other stakeholders including cross-College initiatives, government agencies, external educational bodies, patient advocates and other community groups.

3. Prior to implementation of the revised standard we would require further clarity on the number CPD hours required for those with multiple scopes. Approximately 25% of our Fellows work in rural or regional Australia and have a significantly broader scope of practice than their colleagues in metropolitan centres. As currently presented, it is ambiguous whether these practitioners would be required to undertake 50 hours in each scope, if there is a sliding scale dependent on the amount of time they practice in any given scope, or an alternative model. The statement “the board requires a minimum of 50 hours of CPD activity per year. Colleges may not set a high-level requirement of more than 50 hours of CPD per year, although individual CPD homes may require more than 50 hours of CPD prom their participant” (pg37) is require clarification in order to apply this standard.

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

RACS would ask that the Board consider the following inclusions to the revised standard:

1. In addition to introducing an exemption for those on maternity leave, we would suggest that this be expanded to include paternity leave and adoption leave. Expanding the definition would better recognise the challenges faced by medical practitioners in juggling work and family life, and the importance of equity and inclusiveness in the health system. With an increasing number of women choosing surgery as a career and a rise in blended and non-traditional families, we feel this is more reflective of the modern medical workforce and community.

2. We recommend that the Board consider including a requirement that on renewal of registration, a medical practitioner must append their Statement of CPD Compliance (for the most recent period) to their application. We believe this would provide a more robust mechanism that the existing self-reported declaration of CPD compliance, and potentially minimise repetitious auditing of medical professionals.

4. Do you have any other comments on the draft revised CPD registration standard?

We recognise the amount of work undertaken by the MBA in drafting these standards and the efforts to incorporate a variety of divergent views. Achieving a balance between enforcement of a minimum standard and providing sufficient flexibility to support meaningful engagement in CPD is essential. We would welcome the opportunity to meet with representatives of the Board to discuss in more detail proposed changes specific to the RACS CPD program.

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.

RACS supports the exclusion from CPD requirements of those listed in 5a.

RACS supports the management of exemptions from CPD by the accredited medical colleges, who are best placed to provide support to medical practitioners. RACS supports the remainder be managed by the regulator.

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

RACS has not identified any other group that should be exempt from this standard.

6. Interns

a. Do you agree that interns should be exempted from undertaking CPD or should they be required to complete and record CPD activities in addition to or as part of their training program?

As a representative body for Fellows, Trainees and International Medical Graduates, we do not have any specific comment in relation to interns and CPD participation.

RACS does not at this time have a definitive position on whether interns should be exempt from CPD, however we would welcome further discuss if required.

b. If CPD is included as a component of their training program/s, should interns have to comply with the same mix of CPD as other medical practitioners?

As above.

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

As above.

7. Specialist trainees

a. Do you agree specialist trainees should be required to complete CPD as part of their training program?

RACS does not at this time have a definitive position on whether CPD should be a mandatory component of a specialty training program. At present there are some surgical specialties that are seeking to or have introduced CPD as a component towards the end of their training program while others have not followed this path. We welcome measures that support Trainees understanding of their professional obligations once they have achieved specialist registration and are open to discussion about the proposal but would require further time to fully consider this position.

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

As outlined in 7a, RACS' position is still under consideration. We would however expect that if mandatory CPD participation was introduced for Trainees, that adequate recognition be given to training and assessment requirements already being undertaken within that training program (i.e. Fellowship exams, practice-based assessments).

c. Should specialist trainees have to record what CPD they are doing or is completion of the program requirements sufficient to comply with the standard?

If introduced, we would support maintenance of a record of CPD participation.

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?

RACS supports IMGs completing CPD in addition to their period of clinical assessment.

RACS has an established and robust CPD program for IMGs that is largely equivalent to RACS Fellows. Compliance with this requirement is 100% and includes a total audit of the IMG's activities. Maintaining CPD during the assessment period for IMGs establishes good practice and understanding of CPD once they complete the pathway and transition to Fellowship.

Under the existing RACS framework, IMGs have a pro rata requirement based on their date of intake, with full requirements being achieve over each 12-month period, which may not be for a calendar period. RACS proposes to maintain this standard - on the commencement of their period of clinical assessment - and not aligned to a calendar period.

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?

RACS supports IMGs achieving a uniform standard of CPD as for any other doctor within that same specialty.

In addition to meeting the CPD requirements equivalent to a RACS Fellow, IMG's must also undertake a Multisource Feedback once every 12-month period of clinical assessment. This has been identified as a valuable tool for quality improvement for those under clinical assessment.

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?

RACS supports CPD for IMGs being specifically and separately recorded. This recording forms part of their assessment requirements and requires review separately to the other assessment requirements.

RACS IMGs have access to the CPD online portal to complete their CPD requirements. The RACS CPD portal enables IMGs to upload evidence of completion for activities, as well as a range of other RACS tools and features such as the online learning plan, MSF and auto-population for CPD approved activities. IMGs are also issued a CPD Statement of Compliance for every year of CPD participation.

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?

RACS supports exemptions from CPD for those facing illness, bereavement or in other exceptional circumstances. RACS provides exemptions from CPD for participants unable to practice for more than 6 months in a calendar year and no more than 12 months. RACS may exempt single requirements based on an individual's situation and all exemptions are

approved by the Chair, Professional Standards. Allowing for a degree of flexibility in the interpretation of this standard is essential.

RACS supports the inclusion of exemptions from CPD for those on maternity leave and supports the standard being further expanded to include those on paternity or adoption leave (See response to Q.3).

b. Is 12 months an appropriate threshold?

RACS supports a 12-month threshold for absences from practice. For those unable to practice for a period of greater than two years, consideration should be given to transferring their registration status to non-practicing until such time as they are able to fully comply with the CPD requirements.

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

In the majority of cases, the relationship and peer support networks reside with the specialty College. RACS supports the continuation of Colleges managing and supporting Fellows and other CPD participants through any periods of hardship, illness or other periods out of practice. RACS supports the application of exemptions be managed by the colleges.

While RACS believes the specialist, medical colleges are best placed to support Fellows with exemptions, if there are circumstances where the Board were to grant an exemption from CPD, we believe the specialist medical college should also be notified directly of this situation. RACS are in the process of reviewing our CPD compliance statements and how we can better report/track compliance for Fellows who are given an exemption.

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?

RACS supports the requirement for participation in CPD that aligns with scope(s) of practice. RACS would however like to see further clarification of this standard as the description is currently ambiguous (see response to Q. 2).

In most situations, the specialist medical colleges should be able to support medical practitioners to meet their CPD requirements within their scope.

RACS supports 50 hours of CPD annually and unless compelling evidence is presented that supports an increase in hours, does not believe there is increasing the number of hours is required and is potentially unsustainable. In alignment with regulatory standards, we believe specialist medical practitioners should retain a level of autonomy in determining the professional development activities they require to improve their professional knowledge within their scope.

The RACS CPD framework is currently under review. We are particularly mindful of our Fellows who operate with a broad scope of practice, such as rural and regional surgeons,

and the importance of on-going surgical services to these communities. We acknowledge that surgeons who practice in these settings may face challenges accessing education activities and may not have adequate peer networks. It may also not be feasible to achieve CPD compliance in each year for every scope. RACS is developing a technology platform, including CPD recording function, that will assist Fellows to have greater access to education completed across their scope and support completion in scopes not yet achieved.

While it may be practicable for those with multiple scopes to complete their CPD through with one specialist medical college, it may not be feasible for those with more than one specialty to meet the standard. We appreciate that this may be more problematic for some specialty groups than others and would welcome further discussion more broadly on issues relating to scope of practice.

11. CPD required

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

The requirements are well defined. While the lists of activities are not exhaustive, we do welcome flexibility in ensuring we are able to recognise relevant and evolving CPD activities.

RACS delivers a flexible and bespoke program of CPD activities that supports Fellows to achieve their CPD requirements across the many roles in which surgeons' practice. As highlighted previously within this submission, RACS would welcome further clarification regarding the amount of CPD required within each scope of practice.

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?

RACS supports a framework where all medically registered surgeons using their professional knowledge and skills in any role, including those that don't have direct patient contact, have a uniform CPD requirement. This includes completing a broad range of professional learning activities, participating in high quality education and professional development programs. RACS supports measuring outcomes and reviewing performance as a means of personal improvement and believes a range of activities can be included in a CPD program regardless of a scope to support those in varying roles.

For many years RACS has provided a CPD program which accommodates all participants regardless of the scope in which they practice, including non-operative consulting, medicolegal, surgical assisting and non-consulting practice to achieve compliance. RACS will continue to develop, evolve and expand the program for even greater options and support mechanisms.

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?

RACS considers participation in CPD as a professional obligation that demonstrates a surgeon's commitment to lifelong learning and patient centred care. For this reason, RACS does not strongly support part-time participation in CPD or exemptions from some types of CPD for certain sub-groups (except where required in individual circumstances such as an exemption). RACS supports a flexible approach to the development of CPD programs which offers a broad range of activities sufficient to accommodate a variety of roles and scope.

12. CPD homes

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

RACS supports accredited medical colleges providing CPD programs for all registered medical practitioners. RACS believes that the specialist medical colleges are best placed to understand the needs of their trainees and Fellows, as well as creating appropriate training programs, support mechanisms, and developing and implementing standards.

Consultation with RACS Specialty Societies and Associations has affirmed that RACS is considered the most suitable CPD home for surgeons in Australia and New Zealand. In the case where the Australian Orthopaedic Association (AOA) deliver the CPD program under the RACS accreditation to some orthopaedic surgeons in Australia, RACS works closely with the AOA to support CPD compliance; failure to comply with the AOA CPD standard is managed by RACS, through established policies and procedures.

RACS will continue to develop a comprehensive program to best support surgeons and achieve compliance.

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

RACS is broadly supportive of the CPD home, where is relates to the accredited medical colleges being the provider of CPD and establishing specialty specific programs, education and resources to support the professions.

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

RACS supports CPD compliance reporting on an annual basis.

Currently the RACS program commences on 1 January to 31 December with a completion date of 28 February of the following year. RACS has recently determined that the CPD period will be adjusted to an Australian financial year (as of July 2021), with a completion due date of 31 August and compliance reporting to AHPRA in September. This change streamlines the process of a compliance timelines, gives the program a defined period and establishes a set reporting date to the regulators which also coincides with medical registration renewal.

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)?

RACS supports the reporting of CPD compliance within 6 months of the CPD yearend or to coincide with medical registration renewal, whichever is sooner.

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

RACS supports the inclusion of an audit process within the CPD program of at least 5%.

From 2021, RACS will increase the percentage of CPD participants audited from 7% random selection to 10% annually. Those to be audited will be selected as 5% random selection across eligible CPD participants and 5% randomly selected from those who have never been audited. This change has been implemented to ensure that throughout a 10-year cycle all CPD participants will have their CPD audited at least once.

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

RACS has taken a strong stance on CPD compliance and has maintained 100% compliance for several years. RACS would however support the Board taking a greater role in failure to comply, particularly as medical practitioners have a requirement to declare CPD compliance annually at the time of medical registration. RACS will continue to pursue Fellows CPD non-compliance as a breach of its Code of Conduct. We would however consider that in reporting non-compliance to a regulator, there is then an obligation on their part to respond to this in accordance to the standard (i.e. responding to those who are non-compliant but self-declared that they were compliant for registration purposes).

RACS policies align CPD compliance as a breach of the RACS Code of Conduct. For many years RACS has managed failure to comply with CPD through its Professional Conduct Committee and has included counselling, sanctioning and terminating Fellowship for varying or repeated breaches. In the case of a high-level sanction being applied (i.e. lost off Fellowship), RACS has notified AHPRA of the sanction and will continue to do so.

13. High level requirements for CPD programs

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

RACS supports specialist medical colleges determining scope specific requirements.

Specialist medical colleges are best placed to determine the scope of practice for medical professionals, and the essential knowledge and skills that may be required for a specific scope. Working closely with surgical specialty associations and societies, RACS is developing a matrix of scopes across all surgical specialties to ensure that the technical and professional competencies are captured, documented and incorporated into the CPD program.

14. Transition arrangements

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

RACS intends to introduce a revised CPD framework in 2021 and would support the introduction of the new standards by 2023.