Submission to AHPRA

I feel very strongly about this issue, having had a long and passionate interest in medical education in the General Practice context. I have worked as a medical educator in GP vocational training for the RACGP, a job involving the assessment of GP registrars. I have been a member of the RACGP Quality Improvement and Continuing Professional Development Committee from 1989 to 2016, and its Chair from 1996- 2002 and again from 2011 to 2016. I have spent a great deal of time and effort helping design the College's QI/CPD program for its 20,000 plus participants.

I have come to appreciate the very difficult balance between the educational rigour demanded by the academics and the real life limitations faced by practicing clinicians. To take an extreme view, the educators seem to view practitioners as recalcitrant devotees of lectures and journal reading, to be dragged kicking and screaming into evidence based education, while clinicians view the academics as ivory tower fanatics seeking to impose time wasting navel gazing on them.

Philosophical issues

My fundamental difficulty with AHPRA's proposed CPD standard, is the inclusion of CPD as part of the "5 pillars" of the Professional Performance Framework.

I recall very well the initial drivers for this framework , with much publicity in 2016 regarding risks to patient safety from poorly performing doctors. (REF) The then Chair of AHPRA, Prof Jo Flynn is on record as criticizing college CPD programs for failing to resolve that issue. Obviously a focus on patient safety is an AHPRA role, but I believe a focus on CPD is entirely misplaced. CPD Programs are designed to improve physician performance, and ultimately patient outcomes, but they are not designed to assess performance at a level required to identify doctors whose practice is deficient. "Strengthening" CPD is still not going to do that. I have yet to find international examples of programs that actually achieve that goal.

AHPRA is proposing to disrupt the college-led CPD system, with no guarantee that this will solve the problems it has identified. In my view , AHPRA should concentrate on the other pillars of professional performance, looking at evidence based ways to identify "at risk" practitioners and utilizing date to identify outliers. Much research could usefully done in these areas without disturbing a system which clearly annoys the education academics but with which most practitioners seem reasonably happy. Furthermore , the AMC also seems reasonably happy with college CPD efforts, since it has continued to accredit them.

I recognize that AHPRA has a focus on the individual practitioner, and has no role in accreditation of hospitals or practices. However it is worth pointing out that there is abundant research (both in medicine and in industry) that mishaps and poor outcomes are much more often due to system failure and not to the fault of any individual. In medicine, poor access to care, failures in hospital systems, problems in clinical handover or in follow up of results account for much more patient mishap than does some failing of an individual doctor. Regulators world wide seem to lose sight of this frequently (eg Dr Bawa-Garba's well publicized deregistration in the UK)

It is also noteworthy that recent reports of poor patient outcomes in Australian rural hospitals (ABC Four Corners 2019) talk of " a toxic culture of management" as a major factor in the cause of failures in patient care.

The other important argument against an attack on CPD programs relates to the characteristics of doctors coming to the attention of regulators. At least if we focus on doctors who had an adequate undergraduate medical education and postgraduate training to an Australian standard, my understanding is that most doctors with seriously deficient performance fall into one of the following categories:

- Impairment, either illness or substance abuse
- The pursuit of financial gain at the expense of patient care
- Personality disorder eg psychopathy

CPD, even "strengthened" will neither identify these nor remediate them.

AHPRA itself has a rather dubious history in terms of protecting patient safety. For many years it has been prepared to allow international graduates (IMGs) into the most challenging locations in Australia, with neither an acceptable primary degree nor any effective assessment against Australian college standards and without any detectable supervision.

I think the issue of the profession's trust is important. The profession accepts AHPRA's role in ensuring patient safety, and in responding to complaints about practitioners. However I doubt that most doctors trust AHPRA to control CPD standards. That view is certainly borne out by on-line feedback I have seen. Most respondents want the colleges to continue their role in setting standards for continuing education and professional development for their members.

AHPRA's suggestion that the provision of CPD programs might be opened up the market seems even more disruptive and unnecessary. Colleges are likely to continue to require their Fellows to undertake their specific CPD programs irrespective of registration requirements, which would leave a relatively small number of doctors without a home. Many of these would likely fit into the RACGP or ACRRM programs.

<u>Specific comments on the proposed CPD Standards</u>

Before providing feedback on your specific questions, I have some more general comments on the overarching framework chosen by AHPRA.

- I do not think a one-size-fits-all model will meet the needs of the very diverse range of disciplines making up the medical profession. The great advantage of allowing the colleges to continue to design their programs is their ability to tailor requirements to the needs of their members.
  In particular, outcome measurement is obviously the Holy Grail of performance assessment, but is difficult to achieve in practice. Clearly it is more feasible in some disciplines eg surgical disciplines, where there are some hard numbers we can measure. Even here, there are aspects of surgical work, such as surgical diagnostic skill or communication skills, which are not so easy to measure. In consulting disciplines, and particularly in general practice, patient outcomes are

notoriously difficult to manage. The Quality Outcomes Framework in the UK does not inspire confidence.

Perhaps it comes back to the adage that what is measurable may not be important, and what is important may not be measurable.

- The rigidity of the framework pays no attention to the well-researched are of learning styles. Learning plans in particular do not fit the learning style of some people (perhaps a majority).
- The idea of 50 hours of CPD appears to me to belong to the pre-digital era of lectures and workshops as the major source of information. Obviously the digital age has made a huge difference to information management. We no longer need to carry all the knowledge in our heads. For most clinicians, practice now involves accessing information, guidelines, expert opinion etc at the point of care, with each interaction lasting a few minutes at most. For greater depth, most clinicians will have access to a full on-line library of journal articles, to read up on clinical problems seen that day.

  I am not aware of any CPD programs that capture these "real life" learning experiences, which means that formal programs present a very incomplete picture of a doctor's CPD. 50 hours may not seem much per year, but is in addition to the "real" CPD and may simply be a hurdle that has to be jumped.
- The learning needs of practitioners at different career stages has been ignored here, and in most of the literature I have read. It would seem obvious that the learning needs of a new Fellow are vastly different to those of a 40 year veteran. I have no firm view on what that should look like, but CPD programs should be flexible enough to accommodate those. I suspect learning plans are even less use in the more experienced.
- Mandating activities is a nice idea in procedural disciplines, but a nonsense in General Practice.

If I seem particularly negative about learning plans, that negativity comes from personal experience and experience trying to get doctors to do them effectively. The RACGP experience is salutary. For many years, learning plans were core features of GP vocational training and one of the options in the RACGP QI/CPD Program. With few exceptions, registrars hated them and struggled to produce anything useful. In the CPD arena, when these were optional, despite very clear instructions and provision of helpful tools, the take-up was vanishingly small.

As is well known, the College decided to make this a mandatory component of the 2016-2019 triennium. AHPRA would do well to consider the RACGP experience. Amidst a storm of member protest, a new college President reversed the decision and made it optional again. I hope the RACGP will conduct an evaluation of PLAN with a view to better understanding what happened. It may be tempting to blame the clinicians for being educationally naïve and irrational, but I think that would be very unfair.

By the way, your table of college programs incorrectly states that a Professional Development Plan is a mandatory part of the RACGP Program from 2020. In light of recent experience, I am sure they will only do this if forced to by AHPRA. While the table looks impressive in terms of provision of activities in performance review or outcome measurement, the reality is that most of these are either pretty soft, or very narrow audits and most certainly do not identify seriously poor performance.

Practitioners working in hospitals often have performance review through their employment, and also participate in incident management reviews etc, which achieve this. However doctors in private

practice and GPs in particular , do not have these opportunities. Perhaps work should be done on how to include these mechanisms as part of life in private practice (and a paid part as well!) rather than trying to mandate them via CPD Programs.

Responses to the questions posed in the Standards

I think I have answered Qs 1-5 above.

Qs 6 -7 Interns, and specialist trainees should remain outside this program. The status quo should apply where their educational and assessment requirements are the responsibility of their hospital or postgraduate council.

In addition, PGY 2 and above doctors who are not yet in a formal specialist training program, should not be part of this arrangement eg service registrars. Most of them are trying to get into a specialist training program and life is hard enough for them already without adding more burdens. They are well supervised.

Q8 My understanding is that IMGs will now either be recognized as specialists (and so part of a college program) or else in a formal training program towards fellowship, in which case the educational requirements should apply. Any IMGs still in the system, working effectively unsupervised but without Fellowship, should either enroll in a College Program of meet AHPRAs current default requirement, or any new variation of that.

Q9 Exemptions should be determined by the CPD home organization in my view

Q10 Is extremely difficult for generalists, who often find themselves overwhelmed by competing requirements. This needs a lot more thought. The RACGP has in the past considered mandating CPD across the GP curriculum, but at this stage it just looks too difficult to achieve.

Q11 Most of this is covered in my initial paragraphs.. In the case of practitioners in non-patient contact disciplines , I think their requirement should be addressed by whichever college they belong to.

Q12 Given that participation in the college programs is a criterion for registration, I think it is fair that AHPRA sets some guidelines. An annual requirement is very labour intensive to administer and audit, and I would favour 3 years. I am not sure how AHPRA should handle non-compliers.

Q13 As indicate previously, I am arguing for a greater continuing role for the colleges

Q14 If this proposal is implemented as detailed, I think transition will take longer than you think. Sensible performance review and outcome measurement options are not yet available “off the shelf” and will take time to develop. Despite AHPRA’s optimism that there will be little change, the level of opposition suggests that it will be a major readjustment for grass roots clinicians.

In summary, I am not convinced that there is evidence to support a major disruption to college led CPD Programs.

Peter Maguire

18 January 2020