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14th February 2020

Submission to MBA regarding proposed changes to CPD

Confidential - please keep my name and contact details private and confidential

Thank you for the opportunity to submit to your consultation process. I am a specialist GP with decades of experience in clinical practice in urban rural and remote areas of Australia. I have also been employed by both RACGP and ACRRM in the past in the areas of Education and CPD (RACGP).

We should Retain the status quo – Option 1

My question to you is, what is the evidence that there is a problem with CPD in General Practice or Remote Medicine?

Australia has excellent standards of clinical care and I believe some of the highest in the world.

I believe that the RACGP QI&CPD program which is directly linked to vocational recognition with the Commonwealth has been serving the profession well since its inception and it has evolved over time and introduced high quality education, audit and quality improvement processes within the program. It also introduced structured learning plans, however these were withdrawn as a compulsory element for reasons that I am unsure but suspect poor participant uptake due to lack of ease of access to an appropriate and workable IT platform. The RACGP framework values quality education over quantity of hours and is vigilant in maintaining accreditation of activities that bears its symbol. It can re-introduce structured learning plans into the future with a better IT platform.

I think it is unfortunate that ACRRM has changed its well established PDP system to bend to meet the proposed MBA requirements before these requirements have been implemented and I suspect this will impact into the future on accreditation of activities that require accreditation across both Colleges e.g. Mental Health Skills Training, Emergency Medicine courses. This will shift the emphasis from quality to quantity and reduce everything to how many “hours” is spent in each activity with practitioners potentially choosing the lowest cost option to meet their requirements with as little personal engagement as possible.

So, I believe that changing the CPD standards is not the remit of the MBA but should be retained by the Colleges which can support their members to continue to improve their professional practice.

I would now like to address some of your questions posed on your website

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

NO. For General Practice it is more relevant to retain the existing CPD framework which is evidence based, achievable and considers the circumstances of part-time workforce and more importantly the rural and remote workforce. You draft revised standard is demeaning of the quality of current general practice CPD and only looking at “hours per year”. Whilst 50 hours per year may not seem difficult to a city-based practitioner or office-based MBA Board Member, it may be completely unrealistic for rural and remote or part-time GPs. 50 hours per year of direct face to face or blended CPD may in fact take in excess of 70 hours to organise and complete. It will create an enormous rural workforce issue for locums to fill positions for rural and remote GPs to leave their practices to attend to 50 hours compulsory CPD per year. Defaulting to an hours-based versus the current quality-based system is a very backward step.

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

We should not be moving to the proposed new system but remain with option A – no change. Stick with the current standard which is flexible and run by the appropriate authority for GPs which is the RACGP (since 1995) very effectively and in a quality assured and monitored way that articulates with the Commonwealth in term of vocational recognition.

5. Who does the proposed registration standard apply to?

You are proposing standards that cannot be equally applied across all craft groups within medical practice. The RACGP has had fully functioning and innovative CPD programs for a two decades or more that articulate with the Commonwealth regarding vocational recognition. We have had appropriate CPD home within our College for that time that have well established standards, requirements and have progressed to include more educational planning, quality improvement and other important features such as accreditation of quality activities that earn more points per hour than self-directed low quality activities. Moving to your proposed standard would be a very backward step for all GPs – urban, rural and remote – affiliated with the RACGP.

9. Exemptions

Registration standards should be applied to all practitioners but it is the Colleges that understand the differences within and across craft groups within their part of the profession. The current 3-year cycles of CPD already accounts for part-time doctors, maternity and paternity leave, serious illness, bereavement and exceptional circumstances. They also appropriately support return to clinical practice for doctors where required in close association with AHPRA and MBA so why should this need to be changed when it is currently fair and equitable to all.

11. CPD required

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

NO. Your specified types of CPD are not clear and not necessarily relevant to the diversity of General Practice / Rural and Remote Practice. It does not consider the diversity of General Practitioners or the diversity of practices across Australia.

Under the proposed CPD registration standard all doctors must:

- complete a minimum of 50 hours of CPD per year that includes a mix of:
    - at least 25 per cent on activities that review performance
    - at least 25 per cent on activities that measure outcomes, and
    - at least 25 per cent on educational activities
- have a CPD home and participate in its CPD program
- do CPD that is relevant to their scope of practice
- base their CPD on a personal professional development plan.

I am personally most familiar with the RACGP QI&CPD program that introduced quality improvement activities some years ago. These audit patient records and highlight where guidelines and /or outcomes are achieved or not met and encourage practitioners to reflect on their practice and identify areas for improvement. These specific activities include educational content.

Performance review is a “term” that can be more challenging in General Practice and needs to be introduced carefully and slowly and not via a big stick from the Medical Board of Australia. If you use the big stick you will see an exodus of practitioners who feel threatened for no educationally valid reason. Many already undertake and will be able to undertake into the future multi-source feedback, patient feedback questionnaires and practice accreditation as these quality improvement activities already exist with the RACGP QI&CPD program. The College can guide practitioners towards these activities through stressing their “value” rather than pushing them as an MBA requirement and the linguistics of “quality improvement” versus “performance review" is very important and needs to be nuanced by the College to its QI&CPD participants.

12. CPD homes

CPD homes have existed for a long time in the RACGP and ACRRM who in turn have met their reporting commitments to the Commonwealth. No need for change.

Thank you for the opportunity to make this submission and my final comment is “if it is not broken it does not need fixing”

Your sincerely