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Chair, Medical Board of Australia

By email: performanceframework@ahpra.gov.au

Public consultation on the draft revised registration standard: Continuing professional development. Submission by the Royal Australasian College of Physicians (RACP)

Dear Dr Tonkin

Thank you for the opportunity to comment on the proposed changes to the registration standard: Continuining professional development (CPD). Fundamentally, the RACP supports the Medical Board's proposal to develop a strengthened system of CPD that is robust, evidence based, flexible to meet future needs, and linked to patient safety and improved performance. However, we propose revisions to the standard as outlined below.

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

   It is helpful, clear and relevant in many respects. It is not yet clear whether the changes are workable for many physicians and paediatricians and will be challenging for those in private practice, non-clinical practice, semi-retirement, approaching retirement, in rural practice or those practising part time. Performance review and outcome measurement activities require much better definition and will require considerable lead-time for development.

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

   Proposal for 12.5 hours of activities relating to measuring outcomes

   Measuring outcomes activities are particularly challenging. Within the consultation document (page 28), the Board stipulates:

   "*Under the professional performance framework, the Board will work with other agencies to urge governments and other holders of 'large data' to make data accessible to individual registered medical practitioners to improve safety and quality*"

   Access to data is imperative and should be available for practitioners before the Medical Board implements a mandatory requirement for 12.5 hours of measuring outcomes activities. This will be extraordinarily difficult for some practitioners to complete with little access to datasets. The Medical Board needs to meet its commitments outlined in the Professional Performance Framework (PPF) to make quality usable data available across medical specialties. The Medical Board is at risk of alienating a large portion of the medical community if they insist that all practitioners complete 12.5 hours of measuring outcomes activities at this stage.

It is suggested that the Medical Board adopt a progressive approach in this initial stage, lessen the hourly requirement across categories 2 and 3 and allow practitioners to complete either a mix of activities or activities from just one of the reviewing performance or measuring outcomes categories. This would be in place whilst further work is undertaken by the Board to make quality datasets available across all medical specialties. This should be reviewed in three to five years once additional data is available for practitioners to undertake measuring outcomes activities. Additionally, and importantly, by this point data should be available to support the impact that the CPD changes have had on patient outcomes in Australia, which will provide strong support for future implementation of mandatory requirements for measuring outcomes activities.

Proposal to complete a mandatory professional development plan (PDP)

When compared to the evidence provided by the Medical Board to support other proposed changes, there is less empirical evidence to support a mandatory professional development plan. Practitioners will organise, record and reflect on their learning in a way that suits their learning needs. CPD activities should be flexible enough to allow practitioners to select valuable activities relevant to these needs. The PDP should therefore be optional and flexible. Mandating a written plan and uniform approach is likely to result in a meaningless, box-ticking exercise with little educational benefit for some practitioners.

Mandating hours versus credits/points

RACP does not support the requirement for practitioners to record the number of hours of CPD activities completed or for CPD homes to allocate points that can be translated to hours. It is not an effective record of CPD. Stipulating hours spent as the standard, rather than credits, does not reflect the quality of the activity or incentivise practitioners to complete high value activities. For example, peer review in depth may not take many hours or completion of multi-source feedback may only take five hours. In the current proposal, neither activity will satisfy the Medical Board's requirement for 12.5 hours of reviewing performance activities but both have huge benefits.

The RACPs position in granting higher credits for peer review and measuring outcomes activities helps make a reasonable balance and will incentivise practitioners to complete these activities. The RACP notes the Medical Council of New Zealand's (MCNZ) statement of minimum requirements for providers of recertification programs stipulates that providers must: *"Give greater credit and recognition for activities that evidence shows are most effective and offer the greatest value for improving a doctor's practice."* It is therefore strongly recommended that the Board consider credits as opposed to hours, particularly for reviewing performance and measuring outcomes activities.

Impact on the registration standard: Recency of practice

Currently there are additional regulatory requirements for returning practitioners after consecutive exemptions: Those that have been out of practice for between 12 and 36 months, and have more than two years of clinical experience, are required at a minimum to complete the equivalent of one year's CPD activities. This is required to be undertaken before re-entry to practice. It is not clear how the Medical Board envisions a practitioner will achieve the proposed CPD activities, particularly the reviewing performance and measuring outcomes components, before recommencing practice.

It is unreasonable to expect practitioners to complete these activities, and for CPD homes to provide support, prior to re-entry to practice. A mixture of activities should be

considered both before and upon return to practice. If the Board confirms the CPD registration standard as proposed, the RACP suggests amendments be made to the recency of practice standard to enable practitioners to complete educational activities before returning to practice; participate in performance review within three months of return to practice; and complete activities relating to measuring outcomes within the first 12-months.

In addition, to meet the recency of practice registration standard, practitioners must practise for a minimum total of four weeks full time equivalent in one registration period, which is a total of 152 hours. Alternatively, they must practise 465 hours across a three-year period. The proposed registration standard states that practitioners must complete a minimum of 50 hours of CPD per year. If a practitioner is just meeting the yearly recency of practice standard, their CPD requirement is 33% of their required working hours. That is a significant expectation and many practitioners will be unable to meet this requirement. It may be possible and desirable for the Board to provide flexibility for some practitioners for a short-term period.

Proposal for CPD homes to assess educational quality

There are several references throughout the consultation document that refer to CPD homes 'remaining responsible for the overall quality of CPD activities'. Essentially, the Board is asking CPD homes to both determine what is relevant for each individual practitioner's scope of practice as well as assess the quality of their PDP and the CPD activities completed. Fundamentally, the RACP does not agree with this concept. How can CPD homes, or the Medical Board for that matter, determine what is relevant to a practitioner's scope of practice, of which there are thousands, as well as their educational needs? Further clarification is required from the Board on its expectation for CPD homes to assess educational quality and determine what is relevant for each practitioner's scope of practice.

Defining CPD activities for reviewing performance and measuring outcomes

It will take time and further guidance from the Medical Board to clarify issues around specific activities. It is helpful for the Board to provide guidance to CPD homes on activities claimable under educational activities, reviewing performance and measuring outcomes. However, RACP feels elements of the educational activities outlined on page 27 of the consultation document have the potential to be claimed under reviewing performance or measuring outcomes. For instance, during the preparation of examination questions, there is likely to be robust discussion amongst peers and feedback provided. Some Fellows will claim aspects of this activity under reviewing performance. Additionally, participation in clinical guideline development is likely to require practitioners to look at data and/or best practice as well as make recommendations based on health outcomes.

The level of flexibility CPD homes have to define high-level requirements is unclear and further guidance is required to clarify the types of CPD and how best to achieve what is intended by the Medical Board's changes. The Medical Board should work with CPD providers to clarify what constitutes reviewing performance and measuring outcomes activities, at least during the transition period whilst practitioners adapt to the new requirements.

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

Importance of fostering a positive culture and cultural inclusion

The revised proposal lacks inclusion of the requirement for practitioners to foster respect for the health impact on indigenous cultures and minority groups. The MCNZ's strengthened approach to recertification to embed cultural competency, cultural safety and health equity as foundational CPD elements should be seen as an appropriate contemporary benchmark.

Recognition of the responsibility of the employer

Due to the nature of the standard, the focus is naturally on the practitioner's responsibility and the services of CPD homes. However, employers also bear a responsibility to ensure that practitioners are supported to achieve their CPD requirements, whether practising in a public or private setting. The College is developing significant work in this space through its Physician Health and Wellbeing Strategy. Whilst Colleges can advocate for protected time for practitioners to complete CPD activities, the Medical Board should also clearly stipulate the responsibility of the employer in this standard. Enterprise Bargaining Agreements (EBA) exist as separate contracts for practitioners in public hospital employment in state jurisdictions. Requirements should align with and inform EBA provisions.

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

The proposed changes having a 'minor impact' on the medical profession

Whilst there is generally agreement that the revised standard will strengthen CPD, feedback from a proportion of the Fellowship suggests that the changes will have a significant impact. As outlined in question one, those in private practice, non-clinical practice, semi-retirement, approaching retirement, practising part time or rurally will have difficulty, particularly with performance review and outcome measurement. The changes also impact CPD providers with most, if not all, implementing significant technological changes to reflect the new requirements. Resourcing is required to design, develop and implement the infrastructure to support the new CPD requirements.

Lack of evidence-based data

The Medical Board may be aware of feedback suggesting the changes to the CPD registration standard are not supported by evidence. The consultation documentation does not reflect or acknowledge this perspective. A greater emphasis on the expected effect on patient safety that the changes to CPD will deliver, may assist in getting practitioners onboard. It is clear from consultation with our Members that they do not believe the changes proposed by the Medical Board are a consequence of substantial evidence demonstrating the impact on patient outcomes.

5. 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.

RACP agrees that the cohorts of practitioners listed above should be exempt from the CPD registration standard.

6. 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?

   RACP agrees that interns should be exempt from the CPD registration standard for the reasons specified by the Medical Board on page 19 of the consultation pack.

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

   Fundamentally yes. However, specialist trainees should not be compelled to comply with this standard. The revised standard acknowledges that specialist trainees participate in highly structured training programs, which Colleges are well equipped to support. As part of their training, specialist trainees need to participate in measuring patient/population outcomes. Reviewing performance is already well covered in training programs. If the Medical Board is confident in the rigour of College training programs and also looking to address the accreditation standards to include sufficient structured learning, performance review and outcome measurement opportunities, specialist trainees should not be mandated to comply with the CPD standard.

   If the Board insists on specialist trainees meeting the CPD registration standard, specialist medical Colleges will need further clarity of the implications on compliance reporting, especially for specialist trainees that interrupt their training and/or those that meet CPD requirements but do not progress 'satisfactorily in the training program'.

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

   RACP agrees that IMGs under supervision and SIMGs should comply with this standard. IMGs and SIMGs should adhere to the same mix of CPD and be required to record what CPD they are completing.

   It is noted that the revised standard includes a definition for SIMGs but not for IMGs. This should be included in the standard for clarity.

9. 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?

   RACP supports the proposal to grant exemptions in relation to absence from practice of less than 12 months. However the Medical Board will need to provide better guidance on the 12 month threshold as it is unclear from which year the practitioner is exempt. For example, if a practitioner's parental leave is for 12 months from June to June, for which 'year' can they claim an exemption? The Board should be flexible and support practitioners under these circumstances.

Additionally, the CPD home should grant the exemption as it will make it a more readily accessible process. The Board should provide clear guidelines on granting exemptions to ensure consistency between CPD homes.

10. 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?

    RACP agrees with the Board's proposal that medical practitioners with more than one scope of practice and/or specialty should be required to complete CPD for each of their scopes of practice/specialty and the requirements should be met by one CPD home. Both the requirement for performance review and outcome measurement would be easily accommodated by one home and CPD providers should be flexible to monitor educational activities for more than one scope of practice. After all, many practitioners have forms of practice not covered by existing providers, an example of which could be participation in medical tribunals or other disciplinary bodies outside their primary scope of practice. Additionally, many practitioners are already overburdened with administration tasks and would be very happy if a single CPD home can be achieved.

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

    Somewhat. Further guidance is required to clarify the types of CPD and how best to achieve what is intended by the changes proposed by the Medical Board. The definition for reviewing performance lacks clarity and currently can be interpreted to include activities where practitioners are subject to a review of performance as well as conducting a review of others performance. The standard does not make it clear whether it is the Boards intention for practitioners to be able to claim CPD credits/hours for both activities.

    a. Should all practitioners, including those in non-clinical roles, be required to allocate their CPD proportionately among three types of CPD: activities focused on reviewing performance, activities focused on measuring outcomes, and educational activities?

       Whilst it may be difficult, the Board should consider exemptions from, or at least the possibility for alterations to, the mix of CPD activities for certain specialist groups. Feedback from practitioners has indicated that some simply do not see how they can meet the new requirements. As outlined under question one, many physicians and paediatricians have highlighted the challenges that they will have in meeting 12.5 hours of reviewing performance and 12.5 hours of measuring outcomes activities. It will be especially difficult for those in private practice, non-clinical practice, semi-retirement, approaching retirement, regional practitioners or those practising part time.

    b. 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?

       The RACP believes that the most effective way to manage this is to provide flexibility. In the current RACP framework 100 credits is required and at a minimum 40 of those credits must come from Category 2 and/or 3. This enables a practitioner to make the choice and over time potentially to change that choice as their circumstances change

and as they identify valuable CPD activities that may not be immediately apparent or achievable.

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

Yes, it is clear and workable. However, it is not clear how CPD homes will be accredited. Again, further work by the Medical Board is required to clarify this prior to implementation of the standard.

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

The principles are relatively clear. The principle that '*CPD homes specify the scope(s) of practice for which their CPD programs(s) are designed*' will be extraordinarily difficult for the RACP. There are potentially thousands of scopes of practice within the 39 specialties overseen by the RACP. It would be more appropriate for the standard to state that CPD homes specify the specialties for which their CPD program(s) are designed.

In addition, there are several suggestions that a practitioner may have multiple CPD homes. Whilst a practitioner may choose to have more than one home, the standard should be clear that this will not be necessary for most practitioners to reduce confusion and potential duplication. The Board should also recognise that some practitioners will be obliged to complete CPD with a specified home as part of their Fellowship requirements. CPD providers should be flexible to allow practitioners, with more than one specialty, to choose to meet the requirements of the CPD home that best meets their needs.

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

Reporting on an annual basis will be difficult to achieve for RACP. We suggest that reporting is aligned with the requirements outlined in the College's memorandum of understanding with MCNZ. This requires the RACP to report practitioners that do not meet CPD requirements for two consecutive years. After the first year's non-compliance, the College provides significant support to the practitioner to encourage them to achieve compliance for the next year. It would be helpful for the Board to consider a similar approach.

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)?

The RACP's current approach is to offer a three month grace period, following the years end, for practitioners to complete their CPD records and submit to the College. This runs from 1 January to 31 March. From 1 April, the RACP then begins its audit process and provides significant support to those Fellows with incomplete CPD records. This process runs until 31 July. Therefore, providing a report six months after the years ends will be challenging. It will result in the shortening of the period for the College to provide support to Fellows with incomplete records. This will have an impact on both practitioners and College resources.

Reporting to the Medical Board nine months after the years end will allow larger College's to undertake the extensive work required to complete the audit and incomplete processes outlined above.

It should also be noted that it may be difficult for many CPD homes to indicate whether the

six-month period is feasible without information on what data the Board requires. Complex or lengthy requests for data will require additional time and resources, especially for larger Colleges.

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

The RACP agrees that five percent is an appropriate minimum number of audits for CPD homes to conduct each year.

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

Specialist Medical Colleges are education providers. As the regulator, the Medical Board should take responsibility for appropriate action if participants fail to meet their program requirements following College support. As outlined in question 12d, the RACP provides significant support to practitioners to encourage them to achieve compliance and when requirements are met, a certificate is issued by the RACP. It is the responsibility of the practitioner to demonstrate to the Medical Board that they have met their CPD requirements with the relevant CPD home, and the Board's responsibility to determine action if the practitioner is unable to do so.

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

Yes, RACP agrees that the high-level requirements should be set by the relevant Colleges.

Clarification is required around the following statement: "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 from their participants" (Page 37 of the consultation documentation). The intention here is extremely unclear.

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

Practitioners should have two years to transition. If the transition period is any longer, it may not be effective in altering practitioner's behaviour.

Again, thank you for the opportunity to respond and if you require any clarification or further information, please contact Kate Silvester, Manager Compliance, on 02 8247 6245 or via email: kate.silvester@racp.edu.au.

Yours sincerely

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