The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

7 February 2020

Dr Ann Tonkin
Chair, Medical Board of Australia

By email to: performanceframework@ahpra.gov.au

Dear Dr Tonkin

Re: Public consultation on revised *Registration standard: Continuing professional development*

Thank you for the opportunity to provide a submission to the public consultation on the draft revised *Registration standard: Continuing professional development*.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) supports continuing professional development (CPD) and lifelong learning of all medical practitioners. Completion of the annual RANZCP program is a requirement for Fellows and Affiliates to maintain their RANZCP membership.

In general, the RANZCP agrees with the draft revised standard, and our detailed response to the consultation questions is attached.

The RANZCP continues to have some concerns about the capacity of psychiatrists in private practice to achieve the measurement of outcomes requirements with the same ease as their colleagues practising in the public health system. Accordingly, it will be important for individual psychiatrists to have access to the large data sets currently managed by governments and other agencies to support the measurement of outcomes.

The RANZCP encourages the Medical Board Australia (Board) to make this a priority for the implementation of the draft revised standard so that all doctors have an equal opportunity to meet the measuring outcomes requirement.

The group of psychiatrists who provide services to Mental Health Review Tribunals also have challenges in achieving this area of their CPD owing to the unique nature of their work, where the outcome is a *legal* outcome rather than a *clinical* outcome and the RANZCP believes that there should be reasonable adjustment to the program for this group.

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The RANZCP looks forward to continuing to work with the Board to implement the revised standard once it is published. If you wish to discuss any aspect of our submission in the first instance please contact Ms Anna Lyubomirsky, Executive Manager of Education and Training at Anna.Lyubomirsky@ranzcp.org or by telephone on (03) 9601 4950.

Yours sincerely

Associate Professor John Allan
President

Ref: 1680

Public Consultation – CPD Registration Standard

Response from the RANZCP

The Royal Australian & New Zealand College of Psychiatrists

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Questions for consideration

The Board is inviting general comments on the draft revised CPD registration standard, the concept of CPD homes and high-level requirements for CPD programs, as well as feedback on the following questions.

General questions (relate to part A of the consultation document)

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

   Overall the content and structure of the draft revised CPD registration standard is an improvement on the current standard. Relevant information is provided.

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

   The current content in the draft revised standard does not need changing or deleting, however, guidance on the interpretation of the standard will be important in providing additional explanation of how the standard might be applied for an individual's circumstances.

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

   The revised standard itself is clear and comprehensive; the main item missing that should be addressed through additional guidance documents, is the interpretation of the standard.

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

   The revised standard itself is clear and straight forward. Additional guidance documentation will be important in the interpretation of the standard by individual medical practitioners and CPD homes. It would be helpful to publish any evidence the MBA has collated on the benefits of the proposed CPD requirements. This will assist in assuring medical practitioners of the benefits of the proposed changes

Specific questions (relate to Part B of the consultation document)

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.**

   In general, yes, the standard should apply to all practitioners except those listed above. The exception is the medical practitioner with non-practising registration. It will be important to ensure that any members of this group engaging in any activity relating to their primary medical degree or specialist qualification (for example teaching or review tribunal work) are

completing CPD related to their scope of practice. They should be exempt from the full CPD program.

It is also important to understand how the limited registration types are defined, and the impact on CPD. Having clear advice on how a notation or undertaking on a doctor's registration affects CPD requirements is essential. For example, how does the standard apply to a medical practitioner with current specialist registration and an undertaking not to practice medicine? Or a medical practitioner with current general registration (teaching and assessment) and a notation that they have voluntarily agreed not to provide direct clinical care or prescribe?

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

Specialist doctors who attain the specialist qualification in the second half of the calendar year should also be exempt. During the first half of the year they will have been undertaking structured training with supervision and assessment of performance in the workplace which would meet the minimum required hours for the CPD program.

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?

Yes, interns in an accredited intern training program should not have to meet the registration standard.

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?

Yes, but consideration should be given to phasing in CPD requirements over a period of time.

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

They are in a training position, are closely supervised and receive multiple reviews throughout their internship program. This would more than meet the standard.

7. Specialist trainees

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

Specialist trainees should not be required to complete CPD in addition to, or as part of their training program where they are undertaking a structured training program with workplace-based assessment, supervision and oversight of outcomes by specialist medical practitioners.

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?

Yes, that seems reasonable.

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?

There is no need for additional reporting or recording of CPD as their training records detail the work undertaken,

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?

Specialist IMGs who have been assessed as substantially comparable and who are undertaking a period of supervised practice in a consultant position should be required to meet the CPD standard.

Those who are assessed as partially comparable, and who are in a training/registrar position and completing summative assessments, should not have to do additional CPD to that included as part of their training program.

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?

Yes, for those who have been assessed as substantially comparable.

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?

Partially comparable Specialist IMGs should not have to do additional recording – their training records should be enough.

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?

Yes, exemptions should be grated in relation to absence from practice of less than twelve months for the reasons listed. The RANZCP is pleased to note that exceptional circumstances are now included as grounds for consideration. This recognises that there are other significant personal factors that should be considered as cause for exemption, such as significant family breakdown, illness of a family member requiring the medical practitioner to take on the role of primary care giver, natural disasters.

As previously noted, specialist doctors who attain the specialist qualification in the second half of the calendar year should also be exempt. During the first half of the year they will have been undertaking structured training with supervision and assessment of performance in the workplace which would meet the minimum required hours for the CPD program.

b. Is 12 months an appropriate threshold?

The use of 12 months as the upper threshold is appropriate, as beyond that period there can be an impact on recency of practice requirements.

There should also be consideration of a minimum threshold at which an exemption can be granted. If a medical practitioner is absent from practice for 3 months or 6 months, should they be required to do pro rata CPD?

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

Administratively it would be simpler for the CPD home to grant the exemption. However, the standard states that it is the Board that grants the exemption. The RANZCP is supportive of the Board as the regulator having this role, however, is concerned that this would be time consuming and difficult to administer. This may cause unwarranted additional stress to the medical practitioner seeking the exemption. If exemptions are delegated to the CPD homes, there must be clear guidelines laid out by the regulator on how exemptions are to be granted.

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?

Yes, with some considerations. Where the scopes of practice are within one specialty, or where there is a scope such as research or medical education, it is likely that the CPD can be provided within one CPD home.

Many colleges require their Fellows to complete the college CPD program to maintain their knowledge and expertise in that specialty. It may be difficult to complete all requirements of two specialist scopes of practice in the one CPD home and maintain Fellowship of both specialist medical colleges. This may be addressed by colleges who share a significant number of dual Fellows developing a joint CPD program which recognises relevant aspects of each program.

11. CPD required

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

Yes, the types and amounts of CPD are clear and relevant. The three types of CPD broadly map to the RANZCP current program and can be accommodated. There are some differences in the interpretation of the classification of some activities. For example, research is considered by the RANZCP as a practice improvement activity that measures outcomes rather than an exclusively educational activity, and similarly the development of clinical guidelines is considered by the RANZCP to be a practice improvement activity. The RANZCP believes that these activities should continue to be available to psychiatrists as appropriate activities for the measurement of outcomes.

There is a strong emphasis on audit or audit-related activities in the section on measuring outcomes. Audit activities are more challenging to undertake for private practitioners in a non-procedural specialty such as psychiatry, where episodes of care may extend over many months or years. Psychiatrists in institutional practice have more ready access to activities such as mortality and morbidity meetings and thus can have less difficulty in meeting the requirement for audit activities.

The RANZCP believes that there is a role for its Committee for Continuing Professional Development (CCPD) in this area both in the provision of advice to psychiatrists on what activities can be considered as measuring of outcomes and in fostering creative approaches by practitioners to the auditing of outcomes.

The RANZCP would also support the publication of evidence that supports the types and amounts of CPD in a format that medical practitioners will find accessible.

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?

Whilst the RANZCP supports the principle that all practitioners should do CPD and that there should be a minimum requirement, there are some medical practitioners who will continue to find some aspects of CPD difficult to achieve, particularly those relating to measurement of outcomes and reviewing of performance. Those in private practice have less access to the larger datasets and quality improvement activities that are available to practitioners in the public system, making the completion of activities focused on measuring outcomes more challenging.

Two other groups consistently report challenges in achieving their CPD in the area of measuring outcomes and reviewing performance: psychiatrists who work on Mental Health Review Tribunals (MHRT) and those transitioning to retirement.

Psychiatrists with roles on MHRTs work in a unique space – they are not providing direct clinical care, they are not able to prescribe treatment, yet they have a legal role in determining whether a patient is subject to a mandatory treatment order under the various mental health acts. The public would view them as practising psychiatry, yet in some jurisdictions they are not required to have practising registration. It is difficult for these doctors to participate in outcome measurement or performance review without it being perceived as a 'tick-box' process and there may be reason to consider a variation of the annual allocation of CPD across the three types for this group. Advice from psychiatrists working in this space is that there is generally a rigorous performance review process, however it is not annual. Measurement of outcomes is problematic, as the outcome is a legal outcome rather than a clinical outcome.

Medical practitioners transitioning to retirement also have some difficulty as they reduce their clinical load whilst still being registered. Many will move from clinical work to non-clinical roles, often not in the field of psychiatry and find it difficult to adjust their CPD to their new scope/s of practice. Guidance from the MBA regarding this would be useful to both the individual medical practitioner and the CPD homes.

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?

This could be achieved through consultation with the Specialist Medical Colleges and other significant stakeholders, for example the jurisdictional MHRTs.

The RANZCP would welcome consultation on this matter.

12. CPD homes

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

Yes, this is clear and workable, however will require that medical practitioners have clear advice of the available options for their scopes of practice and for how these will be managed if they have more than one scope or specialty. A listing on the MBA website of accredited CPD homes will be essential.

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

Yes, the principles are helpful, clear, relevant and workable.

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

Annual reporting of compliance is feasible; however, the Board should consider a two-year reporting period which is consistent with the approach taken by the Medical Council of New Zealand (MCNZ). This will also allow Colleges to follow due process with non-compliant members. The 12- month cut off is likely to see regulators having to deal with a large non-complaint group. Colleges can reduce these numbers by working with their fellows and assisting them to achieve the requirements. Regulators are likely to take a more directive position which may promote a 'tick box' response that doesn't promote learning and in the worse case scenario may lead to the fabrication of learning to achieve registration.

The RANZCP would not support 'reverse' reporting, that is reporting of those who are compliant with the CPD program. This would introduce additional reporting processes that add little or no value to the understanding of the CPD program operation and compliance.

The validation of a list of several thousand members would be a significant workload given that there is no common identifier between the RANZCP system and the Medical Register. The validation of the much small set of non-compliant members is the preferred and more workable option, particularly if a two-year reporting period is adopted.

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)?

Six months after the year's end (30 June) is feasible for CPD homes to report on compliance, but there will need to be a transition period for the changes in timelines to be communicated to current members, and for changes to current processes to be implemented.

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

The RANZCP is happy to continue with a 10 per cent audit of records annually. This has been found to be representative of the general College membership in past years and can be used to inform changes to the program.

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

The appropriate action will depend on the relationship of the CPD participant to the CPD home. Where the CPD home is a specialist medical college which requires its members to complete the high-level requirements for its CPD program, then the college should take the actions that is has established relating to those members (Fellows and Affiliates) who are not compliant with the program.

The RANZCP takes a primarily supportive approach to members who fail to meet their program requirements. At the close of the reporting period, non-compliant CPD participants are supported to complete the reporting of requirements. Most CPD participants are compliant – they just haven't recorded the activity. Where there is a small deficit this can be made up in the following year. Where there are larger deficits, or repeated non-compliance, members are currently referred to the Education Committee for further action. There is a remediation program that can be utilized for those members who are having difficulty in managing their CPD. Continued non-compliance could lead to loss of Fellowship, however, this option has not been enacted at this time. Under the proposed revised standard, the RANZCP would support members non-compliant for two years being reported to the MBA.

Where the CPD participant is not a member and has enrolled to complete the CPD as it is related to their scope of practice, they should be reported to the MBA as required by the

revised CPD standard. They should have the same opportunities for support, however for repeated noncompliance the MBA should be the body that acts not the CPD home.

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?

Yes. The specialist medical colleges have the expertise and knowledge of the scope of practice and it is appropriate that they set the high-level requirements.

14. Transition arrangements

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

Following the publication of the new CPD registration standard a period of three to five years would be helpful in ensuring a smooth transition to the new arrangements. The RANZCP program has undergone significant change in the last three years – it has become mandatory for the maintenance of Fellowship, it is now annual rather than having an optional tri-ennium, an online record is now used and the program has moved to an allocation of hours across five mandatory sections rather than a mix of hours and points across a totally self-selected program. It will be important for psychiatrists to have time to adjust to the further changes.

Whilst the RANZCP is already working in anticipation of changes, some changes cannot be implemented until the new standard is in place. Business cases for changes to online systems cannot be scoped until the standard is finalized and are unlikely to be approved until the standard is published.

The changes to mandatory reporting, the associated timelines and potential ramifications, will also need to be communicated to the membership. In common with other specialist medical colleges there is an extended reporting period for participants in the RANZCP program to 31 March of the following year, and the annual quality assurance audit commences in April. These time frames would need to change to meet a reporting deadline for the MBA of 30 June, and as they have been in place for many years this change will need to be managed.

Similarly, any changes to the management of exemptions will need to be widely communicated to doctors, particularly if exemptions are to be granted by the MBA rather than the CPD home.

Ensuring that specialists, who are currently completing self-guided CPD rather than a program through a specialist medical college, engage with an accredited CPD home may take some time. Advice from the MBA on how it intends to advise this group on their options for CPD homes would be helpful.

Any new accreditation arrangements required for CPD homes will need an extended period of consultation and implementation given that they are currently an integral component of the AMC accreditation of the specialist medical colleges.