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Executive Office, Medical
AHPRA
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Melbourne VIC 3001
Email: performanceframework@ahpra.gov.au

Re: Consultation on revised CPD Registration standard.

Dear Sir/Madam,

Thank you for the opportunity to make a submission on the Medical Board of Australia's proposed revised CPD Registration standard.

I am writing on behalf of myself and my colleagues at the South Coast District Hospital Emergency Department, on the Fleurieu Peninsula in South Australia. We are General Practitioners who would fit the proposed Rural Generalist model of specialist, and have extensive experience working in both city and rural general practices, rural and regional hospitals across various states, tertiary hospital emergency departments, and currently provide emergency and some anaesthetics services to our regional hospital.

In the past year, we have also supervised junior registered medical officers as they rotate from tertiary hospitals, and look forward to welcoming GP registrars when possible. Their exposure to the breadth and complexity of rural emergency medicine has been a valued experience that has increased their confidence and competence.

Context

To put the proposed CPD changes into context, it is worth reviewing the current figures for doctors and the stated "objective of protecting the public by ensuring that only those who practise in a competent and ethical manner are registered".

Ahpra's annual 2018/2019 report cites the following figures:

- 118,996 medical practitioners, of which 71,524 - or 60.1% - are specialists.

  The largest group within this category are:
  General Practitioners - 26,772 - or 22.5% of all practitioners, and 37.4% of all specialists,
  followed by Physicians - 11,158 - or 9.4%, and 15.6% respectively.

- 6,970 – or 5.9% - medical practitioners had notifications made about them.
- Of 4,801 notifications closed, 73.8% required no further action.

- This equates to 3,427 - or 2.9% - of medical practitioners with variable actions taken, ranging from conditions imposed, cautions, reprimands, referrals to another body or health complaints entity.
- Of particular note, 895 - or 0.75% - of medical practitioners were monitored for health, performance and/or conduct.

These figures equate to 115,545 - or 97.1% - of medical practitioners continuing to deliver good clinical care with a strong emphasis on patient safety and improving patient outcomes.

This is a fact to be celebrated, and should inspire consumer confidence that Australians continue to benefit from excellent health care, and that medical practitioners continue to practice in a safe, respectful and ethical manner, as well as maintain and improve their clinical skills in line with evidence based best practice and clinical experience.

This perspective needs to be taken into account, as the proposed changes to CPD are neither minor, nor of minimal cost in terms of time, money and administrative burden, and do not provide compelling evidence of superiority compared to existing CPD programmes.

Most importantly, the proposed changes to CPD have not demonstrated a clear effect on improving patient outcomes.

These statements are expanded upon below, with quotations coming from either the draft consultation paper, the Expert Advisory Group final report on revalidation, or associated documents listed on the medical board's website.

Hours versus Points, Annual versus Triennial.

The Board's assertion that "the proposed draft revised CPD registration standard does not propose significant changes to the current arrangements for the majority of medical practitioners" is at odds with the statement that "No colleges meet all the proposed requirements, with only some binational colleges coming close."

The proposal to mandate an annual 50 hours of CPD, with a further prescriptive breakdown of activities, of which a strict 50% relates to performance reviews and outcomes measurements is neither practical to implement, nor proportionate to public risk.

As per the table outlining Existing CPD arrangements of specialist colleges, 75% of colleges allocate points rather than hours, and they allocate higher points for higher education value. This is an example of the favoured strengthening of CPD with a "smarter not harder" approach, which the various specialist colleges continue to refine.

Further, 50% of colleges have 3-year CPD cycles, and 19% have cycles of 2 or 5 years, taking the total to 69% of colleges with non-annual CPD requirements.

Having CPD cycles that span a number of years, with higher points awarded for higher value activities, is clearly working, given the fact that 97.1% of medical practitioners are delivering quality patient care, and 96.8% are fully compliant with the registration standards.

These CPD programmes have been broadly accepted by medical practitioners, and are flexible, relevant, practical and proportionate. They already include opportunities for quality improvement, including performance reviews and measuring outcomes, as well as the critically important educational activities, which often incorporate the earlier categories to varying extents.

Provision for non-specialist medical practitioners to align themselves with a CPD home could be reasonable, and allow them to take advantage of CPD across all 3 categories, as defined by the college that best aligns with their area of practice.

Reviewing Performance and Measuring Outcomes

Broadly, whilst 'Reviewing Performance' and 'Measuring Outcomes' can be positive feedback mechanisms that may improve clinician practice, there is much more evidence for the CPD component of 'Undertaking Educational Activities', also known as CME (Continuing Medical Education), particularly when it is an interactive education event.

Further, the systematic reviews cited in the EAG report on revalidation "do not explain what strategies are most effective, under which conditions, and for what purposes", and "the effect of CPD on patient outcomes has been more difficult to demonstrate…"

Performance review and outcomes measurement are an ongoing process, embedded within individual patient care, and incorporated in high value CPD educational activities, already provided by or accredited by the specialist Colleges.

Mandating a separation of these categories within CPD is an artifice, that does not stand up to best evidence-based practice, and has not demonstrated that these exclusive activities improve patient outcomes, as opposed to being incorporated within CPD as a whole.

Further, given the lack of evidence of improved patient outcomes, assigning such a high proportion of CPD activity to these 2 categories, and on an annual basis, cannot be considered proportionate, practical or fair.

Limited evidence for Audit, concerns over 'Large Data' usage

According to the EAG final report on revalidation, "the practice of audit and feedback in healthcare professional practice has not consistently been found to be effective", and the "clinical audit was most effective when health professionals were not performing well to begin with".

Once again, 97.1% of medical practitioners do not fall into this category, and the Medical Board's push to mandate annual and time-consuming audits is onerous, punitive, and will displace time better spent on productive CME, and the actual delivery of patient care.

Additional barriers to performing Audits include "poor management, lack of audit/organisational support, excessive workload, and time constraints." The latter two barriers are particularly prevalent in General Practice, where existing regulatory burden and poor remuneration have contributed to a steady erosion of General Practitioners, and a dearth of Registrars willing to work under such conditions.

These barriers are also present within the hospital system, progressively worsening in the regional and rural health networks.

In addition, the Board's recommendation of "working 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" will have significant administrative and time costs for private practices, federal and state government health departments, hospitals, Primary Health Networks and clinical registries.

The costs associated with implementing these changes will be borne by "Individual medical practitioners … and Employers."

Government Health Ministers and Health Departments, both State and Federal, would need to expect that administrative costs would increase, as well as take doctors' time away from delivering health care, for questionable gain in terms of patient safety.

Whether intentional or not, the result will be a perception of active surveillance of all doctors, with secondary regard to patient confidentiality, and limited evidence that these measures will improve patient outcomes proportionate to the resources consumed.

Closing Comments

The proposed revised CPD Registration standard

- mandates CPD in a rigid, prescriptive manner
- supercedes the established and evolving specialist college CPD programmes currently in place
- urges holders of 'large data' to make their information available, raising issues of patient confidentiality
- adds to the cost and time burden of individual practitioners and employer groups, including all levels of government health departments
- concedes that there is inadequate evidence that patient outcomes will be improved.

Taken individually and as a whole, these proposed changes contravene the COAG Principles for Best Practice Regulation.

As such, we reject the proposed revised CPD standard as being rigid, disproportionate, impractical, and unfair.

We invite the Medical Board of Australia to broaden its perspective to appreciate that over 97% of practitioners continue to practice safely, with the aim of improving their patients' health outcomes as their top priority.

We also invite the MBA to consider the broader issues of doctor morale, workforce planning, and net migration patterns, particularly in countries with additional regulatory burdens, and consider whether these measures have lead to improved patient outcomes and access to timely medical care as compared with Australia's health record.

We continue to advocate for the delivery of a robust, efficient and flexible health care system that adapts to changing patient requirements and improving health outcomes, and we look forward to collaborating with stakeholders to this aim.

Yours faithfully,

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