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Revised Registration standard: Continuing professional development

AMA submission to the Medical Board of Australia on the proposed Registration standard: Continuing professional development.

Medical Board of Australia
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Thank you for the opportunity to provide comments on the Medical Board of Australia's (the Board) proposed revised *Continuing Professional Development Registration* standard.

The AMA lobbied hard against the ill-thought-out Revalidation proposal, which resulted in a vastly improved Professional Performance Framework based around enhanced continuing professional development.

As part of the consultation on Revalidation, the AMA recognised the value of introducing extra measures to improve patient safety but urged instead the adoption of an approach that builds on the many systems already in place that support doctors in delivering high quality care. Australian doctors already practise in a highly regulated environment.

The AMA understands that this revised *Continuing Professional Development Registration* standard is a strong part of that framework approach. We recognise and support the efforts that the Board has undertaken to date to utilise and build on existing Continuing Professional Development (CPD) arrangements as well as the Board's stated desire to ensure that the final standard does not require practitioners to undertake more CPD than they already do now.

Despite the Board's commitment to not increasing practitioner workloads, there is significant concern among members of the medical profession that this major change will result in exactly that, along with increased costs. The profession must be reassured that the Board has taken a forensic analysis of the changes proposed and demonstrate that it is listening to the concerns that members are expressing about several aspect.

In progressing work on this standard, the Board must be open to adjusting its approach and ensuring that changes only occur where they are supported by evidence, there is demonstrable benefit and they do not increase workloads and costs. The AMA believes that there is still

significant work to be done in developing any final approach and that this needs to be done in close consultation with the profession.

We predict this process may be difficult for some, although not all doctors. The ability of some medical practitioners to measure their outcomes is relatively straightforward, for others it is far more problematic. For GPs, engagement with the new Practice Incentive Program Quality Incentive arrangements will need to be explicitly recognised for CPD purposes.

It is also important that the proposed CPD activities have clear definition, scope for easy completion by doctors working in any setting, and preferably relate to a clear evidence base. The AMA would like to ensure we are at the table for the further development of this proposal.

The AMA agrees with the Board's position of not creating an entirely new process through this revised standard. We agree that the preferred approach is to extract more value from existing CPD programs and routine clinical activity, while still encouraging development and innovation.

For example, we would not envisage doctors spending considerable time on root cause analyses or quality assurance activities to be generally helpful or part of routine practice. By contrast, multi-disciplinary team meetings, clinical audits, and surgical case conference are more mainstream. It should be recognised that doctors working in some settings, for example small private practice or rural/regional areas, might have access to less infrastructure and administrative support to complete new CPD activities.

We are also concerned at the potential one size fits all approach that the Board proposes, particularly with respect to arbitrary rules around the mix of CPD and the number of CPD hours prescribed. The proposed mix of CPD may not be appropriate for the needs of some doctors, particularly when they are in prevocational and vocational training and are undertaking training that is designed to fit with their training program.

We also know that many Colleges currently use a points system to determine CPD compliance and these are well accepted. While the Board has agreed that this approach may continue, it appears that the points required will still need to equate to an arbitrary 50 hours CPD per annum, rather than being focused on the quality and value of CPD that is undertaken. This arbitrary rule is something that needs to be given further consideration as to whether or not a more flexible approach is warranted, particularly given the proven record of existing College CPD arrangements.

The AMA welcomes the decision to open up CPD arrangements, through the introduction of CPD Homes, in order to give doctors more choice as well as better supporting those doctors who do not hold a recognised College qualification or are not currently part of a recognised training program.

The AMA supports standards that are evidence based and demonstrated to show improved performance. The AMA would like to provide the Board with the following comments on the draft standard.

General questions

1. *Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?*
2. *Is there any content that needs to be changed or deleted in the draft revised standard?*
3. *Is there anything missing that needs to be added to the draft revised standard?*
4. *Do you have any other comments on the draft revised CPD registration standard?*

As the doctor in training (DiT) experience is very different to the consultant experience, the AMA believes that the specific needs of DiTs need to be recognised within the draft standard and the way in which it is applied.

Doctors in training who are working towards specialist qualification, in our view, are seeking to develop their expertise as opposed to maintaining it. The extent to which they have ultimate responsibility for patient care also differs from their specialist colleagues and doctors such as career medical officers; as they are not directly responsible for decision making, they are not directly responsible for patient outcomes.

It therefore makes sense that the proportion and type of CPD activities required by doctors in training should differ to that of other doctors. For example, different weightings could be applied to CPD categories.

If the Board is intent on applying the same framework to doctors in training as it does for other registrants, a clear explanation must be provided as to acceptable and feasible activities to be undertaken for compliance, within the usual scope of practice of doctors in training at different points in their professional development.

Further, the cost of meeting CPD requirements (in terms of time and financial investment) for doctors in training must not be unreasonable/in excess of current training requirements.

Other issues for clarification in respect of doctors in training include:

- whether CPD activities will be able to be used against a candidate for selection into formal training schemes or employment - we would not support this.
- which entity will be responsible for following up on under-performing trainees, particularly if they are not in an accredited prevocational training post or specialist training program.

Application of the proposed registration standard.

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

The AMA agrees that the *Continuing Professional Development Registration* standard should 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.

The exclusion of interns is seen as reasonable, so long as the Australian Medical Council maintains a close and continuing focus on the quality of intern training across all accredited sites. We also propose an alternative approach for prevocational doctors that is outlined later in this submission.

The AMA supports provisions within the standard that allow for specialist trainees to meet CPD requirements by participating in a specialist training program, and notes that specialist trainees will not be required to record their activities to meet the standard.

The AMA does have concerns about how this framework will apply to prevocational trainees in unaccredited training positions and non-vocational senior house officers. This group are most vulnerable to potential exploitation within their workplace and potentially have less opportunity for structured learning or review of practice. The proposal is not clear (at least to the AMA) as to how these doctors may organise their CPD safely and effectively. The Board will need to consider the needs of this group carefully to ensure that they are well supported and who will provide oversight to their learning.

It is the AMA's position that any prevocational doctor working in an accredited training place should be exempted and indeed support the accreditation of all prevocational training places. In our view, this would be a better way to guarantee patient safety and improve the quality of the training experience.

In relation to this discussion, we have defined pre-vocational doctors as doctors who hold general registration and who have not yet entered a College-based specialty training program or obtained specialist registration but are working to do so. This group is under direct supervision by specialty trainees and specialists. They currently meet CPD standards by participating in education programs provided by employers, as well as often spending large amounts of time and money on training courses and examinations necessary to facilitate competitive entry into College training programs.

This is distinct from non-vocational practitioners - doctors with general registration who have actively decided not to pursue a training pathway. This group has no current mandated supervision or education other than current CPD requirements for self-education. This group are not directly observed.

If the Board decides to proceed with CPD requirements for prevocational doctors, then it is important to acknowledge that this cohort are already heavily supervised, have on the job learning and are training continuously. If CPD is required for prevocational doctors, then the Board will need to be clear and explicit regarding reporting requirements for this cohort. Such requirements should also ensure that prevocational doctors continue to develop a broad skill set that allows them to pursue a range of different careers.

The AMA would expect that prevocational doctors and non-vocational practitioners will need a CPD Home that can facilitate access to a broad range of professional development activities to align with their various workplace rotations and the varied scopes of practice these practitioners may have.

Continuing professional development for Interns

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.

   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?*

A different mix of categories of CPD should apply given the purpose and structure of the intern year.

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

Completion of program requirements are sufficient for interns to comply with the standard as they currently participate in highly structured, accredited training programs. Interns should not have to record separate CPD as the accreditation of the training post should ensure adequate educational opportunities of a high quality. In places where accreditation (by post graduate medical councils) extends to Postgraduate Year (PGY) 2 and sometimes PGY3, the same rationale should apply.

Continuing Professional Development for Specialist trainees

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

The AMA supports provisions within the standard that allow for specialist trainees to meet CPD requirements by participating in a specialist training program.

We agree there is an opportunity to revise accreditation standards for specialist medical training to ensure that College programs include sufficient structured learning, performance review and outcome measure opportunities to meet CPD requirements.

To assist the implementation of this standard for specialist trainees, the Board might consider running a workshop for medical colleges to promote leadership and innovation in this space.

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*

No. College training programs have been carefully designed to support learning, appropriate to the specific speciality and the trainee's level of experience. The mix of CPD for trainees should reflect this as opposed to a one size fits all approach.

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?*

The AMA agrees with the position proposed by the Board that specialist trainees will not be required to record their activities to meet the standard.

Continuing Professional Development for International Medical Graduates

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?*
    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?*
    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?*

The AMA supports the Medical Board's proposal that international medical graduates should not be required to do any additional CPD provided the activities outlined under their supervised practice plan align with the agreed new CPD requirements under the Standard. The AMA would expect that the supervised practice plan would be cleared sufficiently for this purpose by the practitioner's accredited CPD Home. If the plan is not, the AMA would expect that the CPD Home would work with the supervising practitioner to modify the plan to ensure that in completing it the practitioner has met the CPD requirements.

Continuing Professional Development – Exemptions

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?*

The AMA agrees with the Board's proposal to grant exemptions for parental leave as well as serious illness, bereavement and exceptional circumstances. The Board's language is confusing as it currently refers to periods of up to 12 months and then later refers to periods of less than 12 months. Given parent leave provisions generally provide for a standard period of 12 months absence, this should be the minimum period reflected in the standard.

The Board should also give consideration to how to deal with absences beyond 12 months. In this regard, the Fair Work Act allows for an extended period of absence on parental leave of up to two years. The Board should also give consideration to how to deal with those medical practitioners who have a graduated return to work after a period of parental leave and must juggle the competing demand of work and training with those of being a primary carer.

We would also like clarity with respect to what arrangements will apply to those practitioners that take time out of the workforce to undertake research, study or to undertake training overseas.

    b. *Is 12 months an appropriate threshold?*
    c. *Should CPD homes grant these exemptions or should the Board*

For simplicity, CPD homes should be able to grant exemptions although the rules and criteria will need to be consistent, clear and not open to interpretation.

Continuing Professional Development for practitioners with more than one scope of practice or more than one specialty.

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?*

Throughout the consultation paper, the Board appears to make the assumption that its CPD changes will not increase the workload on practitioners and this assumption extends to those doctors with more than one specialty/scope of practice. In this regard, we believe the Board should undertake a mapping exercise of common dual qualifications to properly assess the extent to which there is commonality in CPD requirements and to ensure that doctors are not being required to undertake anywhere up to double the CPD requirements faced by other registrants. This is particularly important in encouraging generalist practice.

We also suggest that the relevant Colleges work together to design CPD arrangements that support these practitioners and ensure that as far as possible, these Fellows comply with CPD arrangements without having to exceed the usual number of hours required for other registrants.

Continuing Professional Development Requirements

11. CPD Required

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

The AMA believes that the types and amounts of CPD requirements are clear, but notes our earlier comments about the shortcomings of a one size fits all model. For example, the ability of doctors in training and diagnostic specialists (imaging and pathologists) to measure 'outcomes' is limited and the mix of CPD needs to be relevant to the career stage of a doctor.

The AMA also believes that there should be greater flexibility for Colleges to continue with a points based approach to CPD that reflects the value and relevance of the CPD undertaken, as opposed to the quantity of CPD. Colleges are well placed to assess the value of different CPD activities and there is a concern that trying to establish a point based system that also seeks to satisfy an hours requirement will prove problematic and encourage CPD based on activity as opposed quality or outcomes.

Continuing Professional Development Home

12. CPD homes

a. *Is the requirement for all practitioners to participate in the CPD program of an accredited CPD home clear and workable?*
b. *Are the principles for CPD homes helpful, clear, relevant and workable?*
d. *Should the reporting of compliance be made by CPD homes on an annual basis or on another frequency?*
e. *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)?*
f. *Should the required minimum number of audits CPD homes must conduct each year be set at five percent or some other percentage?*
g. *What would be the appropriate action for CPD homes to take if participants failed to meet their program requirements*

The AMA supports the requirement for all medical practitioners to participate in the CPD program of an accredited CPD home and believes that it is a clear and workable model, provided that strong professional ownership of CPD standards remains and accreditation arrangements are focused on maintaining the quality of CPD.

The AMA also supports the possibility of new CPD homes being formed, especially for practitioners who are currently not a member of one of the colleges. The AMA acknowledges and supports that the formation of new accredited CPD homes would provide greater competition between providers to deliver a valued program of learning and highly functional recording and tracking mechanisms to support practitioners in meeting CPD requirements.

Such an approach will provide competition and assist in keeping organisations accountable, but hopefully also facilitate access for doctors to participate in all facets of medicine and geographic areas. It may be that new providers could be innovative in their approach and cater for the issue of two specialties. The AMA supports the idea that proper governance and auditing is critical to the management of CPD homes.

With respect to the frequency of reporting, we note that most Colleges have a cycle that runs over a number of years. This appears to work well and the move to an annual reporting requirement may well impose a significant extra burden on practitioners for no extra benefit. In this regard, the Board should consider allowing Colleges/CPD homes to retain this approach and discuss with them other suitable mechanisms to ensure that CPD is a regular and ongoing part of practice.

In terms of the failure of a practitioner to meet requirements, this is something that CPD Homes will need to take steps to avoid. They should be required to monitor ongoing compliance and have in place systems and processes to support those practitioners who are falling behind or appear likely to fall short of requirements.

Requirements for Continuing Professional Development programs

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, recognising that these should be evidence based. In doing so, Colleges must recognise the full scope of CPD activities that are available to medical practitioners in order to avoid increasing the workload involved in CPD.

Transitional Arrangements

14. Transitional Arrangements

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

The AMA believes that the *Continuing Professional Development Registration standard* proposed by the Board is a significant departure from the current approach and therefore requires a generous transition period. Factors to take into consideration with respect to the timing of any transition would include:

- The timing of current College CPD cycles;
- The resources available to support a revised CPD mix;
- The need to extensively review current College training programs;
- The lead time required for CPD Homes to be established;
- The progress of the development of the two year capability framework for PGY 1 and 2 doctors, including the move towards entrustable professional activities;
- Existing work considering the accreditation of PGY3 to 5 roles in public hospitals.

The AMA is prepared to work with the Board to develop an appropriate transition plan, the form of which will ultimately depend on the final content of the standard and the extent to which the concerns outlined in this submission are adequately addressed.

Conclusion

The AMA supports the Board's approach that CPD programs should give practitioners a wide range of activities and that they should be flexible enough to accept work activities that have an educational component and enable these to be counted. The final form of this standard must be consistent with the Board's stated commitment not to increase the workload on registrants.

The AMA agrees that the question of practitioners in a non-clinical role is a difficult issue. As are groups such as non-interventional radiologists and pathologists. The AMA advises seeking input from the relevant specialty colleges, societies and associations including the Royal Australasian College of Medical Administrators.