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**From:** Kamara [redacted]
**Sent:** Friday, 13 December 2019 11:29 PM
**To:** AHPRA.Consultation
**Subject:** CPD

**Categories:** Acknowledged

To AHPRA,

I am a full-time GP, mother of 4, and new business owner, having recently taken over a small practice where I am the second GP. I have a therapy dog, which required private training out of my pocket, and I have a special interest in skin cancer, and a large clientele with mental health problems.

The new CPD proposals have 2 major flaws as far as I can see.

Firstly, the breakdown between types of educational activities is unnecessary and requires time that we do not have spare in the first place. Planning for what education we feel we need at the start of a triennium is difficult enough, as we have no idea what programs will be offered during the three years that will satisfy those needs. Changing that to an annual chore will not improve things, and will add to our stress levels for no good reason.

GPs already spend a huge amount of time on self-reflection, and asking us to document that reflection is like asking a surgeon to personally record the outcome of every surgery. We track multiple outcomes for our clients with every single appointment, but collating these outcomes is extremely difficult. This is an administrative task that is pointless to our personal growth, and belongs in the realm of the Department of Health pen-pushers and PowerPoint presenters. We do not need more administrative activity taking our energy away from our areas of expertise, which is providing exceptional primary care in a highly cost-effective manner.

Quality improvement is another goal which, while idealistically desirable, is practically fraught with many MANY difficulties. Researchers spend their working lives trying to prove cause, effect, and optimum treatments, and we can hardly pretend that our 12.5 hours per year will yield anything meaningful or significant. Instead, this will become yet another onerous chore that we lie about to satisfy your quest for "evidence-directed" learning strategies. (And on that note, where is the actual evidence-based proof for this type of learning? I was the first year in the highly-lauded changeover to "Self-Directed Learning" and I can tell you that the system failed on many levels.) I would like to see proof that your Quality Improvement strategies result in statistically and <u>significantly</u> better patient outcomes before I waste my valuable time on any such activity.

Peer-to-peer learning also happens on a regular basis in most group practices, where we consult one another about difficult cases. Moving now to a smaller practice, I have finally removed myself from the job of teaching registrars (which I have done continuously for the past 5 years, even when I haven't been their designated supervisor). These unscheduled chores eat into our days, and often extend into our evenings. And now you ask us to do more, taking time away from our workplaces, our families, and our own personal care.

I can tell you now that any PLANned learning I do if this proposal goes ahead will be written with purely my needs in mind. And any quality improvement items will be pulled straight off the database by the newly-installed "TopBar" from our local PHN. My peer-to-peer learning will be conducted in a pub or restaurant with local friend GPs where we will all talk shop, about difficult cases, management dilemmas and bizarre medication interactions, and NONE of it will be written down, but will instead be kept in my head where it will actually be of use to me. My CPD study is for MY benefit

and for the improved management of MY patients, and I will not be putting pen to paper or finger to keyboard to prove this to your organisation.

If you want suggestions that would yield better health for GPs themselves, how about stipulating an annual check-up with a GP and appropriate time off for exercise, mental health, family life, physical rehabilitation, and supports for childcare, business management, and work-life balance optimisation. Oh that's right, we're supposed to do that ourselves, in our spare time, while still providing exceptional primary care, preferably in a bulk billing environment where appointments are available same day and waiting times are minimal. No wonder the applications for General Practice are falling rapidly - GPs are expected to be human but robotic, time efficient but empathetic, balance risk against cost against excessive investigation, assess presenting complaints thoroughly while focussing on patient priorities, and all within ten minutes.

Maybe I need to consider a change of job too.