Is the professional performance framework adopted by the Medical Board of Australia and the proposed new registration standard for CPD appropriate regulatory standards to ensure that General Practitioners remain competent to practice and enhance patient protection?

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Introduction:

The changing face of General Practice:

Throughout the thirty plus years that I have been a General Practitioner, I have seen patient's medical records go from five by eight inch cards to A4 paper in manila folders, both of which were frequently misfiled, to fully computerised records that could not be altered and which prompted GPs to perform health checks and warned of potential medication interactions. I have seen medical meetings and conferences change from drug focused to patient outcome focused with medications being de-identified with regards to brands. Solo GP practices have been 'swallowed up' by large corporate entities. The huge influx of foreign trained GPs has also greatly changed the face of General Practice. By 2017, there were more full-time GPs who were trained overseas working in Australian general practice than locally qualified GPs and less than 5% of the GP workforce was working in a solo practice and 86% were working in a group practice.[1] However, the most important change in General Practice is accountability of doctors to positive outcomes for patients and patient protection. Through the work of the Medical Board of Australia (MBA), focus has been on the care given to patients and on continuously improving the knowledge-based standards which are vital to keep pace with the quickly evolving pharmaceutical and medical technology fields.

I was speaking to a colleague recently, an overseas trained 60 plus year old surgeon who 'defaulted' into general practice as he did not want to sit the rigorous surgical exams in order to work as an accredited surgeon in Australia. He, like no doubt many doctors, believes that the Continuing Professional Development (CPD) program was established in order to gain

[1] RACGP, 'General Practice: Health of the Nation 2018' <https://www.racgp.org.au/download/Documents/Publications/Health-of-the-Nation-2018-Report.pdf>.

more control of General Practitioners by the Medical Board and does not see its value. He does not see that the CPD is not only a way of encouraging practitioners to keep abreast of ever-changing medical fields but also a way of uncovering practitioners who under-perform and place patients at risk. However, as altruistic as this concept is, the current CPD falls quite short of enforcing learning about many specific topics regarding changing, evidence based treatment guidelines as practitioners are allowed to choose the topics that they are interested in and it is probable that the 'self-reflection' criteria of the CPD also does not truly encourage learning about unfamiliar topics that a general practitioner will ultimately come across in their practice.

I believe that GPs are, on the whole, proud of what they have achieved. However, this does not extrapolate into patient protection and improved patient outcomes. I will be proposing a vastly different approach to how GPs are to be encouraged to comply with *continuous* and not just *continuing* professional development in all areas that cover what a GP should be aware of to ensure patient protection.

The evolution of Continuing Professional Development (CPD):

Australian States and Territories convened in the Council of Australian Governments (COAG) summit to establish a uniform national registration and accreditation scheme, which was agreed to on 26 March 2008.[2] Victorian legislation (*Health Practitioner Regulation National Law Act 2009* (Vic) (NL)) became operational on 1 July 2010. The purposes of the legislation was to regulate all health practitioners in all fields relating to the treatment of the public regarding health matters as well as the registration and training of students (Part 1(3)(1) NL), protection of the public by ensuring that health practitioners remain suitably trained and competent (Part 1 (2)(a) NL) and enable practitioners to move and work interstate with greater ease and flexibility (Part 1(2)(b) NL). The legislation strives to ensure that education of health practitioners was of a high quality (Part 1 (2)(c) NL) and that there is continuous development of health service delivery to the public (Part 1(2)(f) NL) – this is where the CPD becomes a valuable part relating to the legislation.

[2] *Health Practitioner Regulation National Law Act 2009* (Vic).

CPD was introduced in 1989.[3] The structure of the 2017-19 triennium has been obtaining a minimum of 130 QI & CPD points within which must include two Category 1 activities (with one being a quality improvement activity), a Cardiopulmonary Resuscitation (CPR) accredited course and the remaining being an accumulation of Category 2 points.[4] QI & CPD activity points for the triennium with Category 1 activities attracts 40 points and Category 2 activities attracts 2 points per hour.[5] There are no proposed changes to the Category 2 activities and the points acquired through these activities. The proposed changes to the CPD program are few, but I feel that they are more burdensome, apart from the fact that the only way to become accredited for Category 1 activities is through scrutiny and acceptance by the RACGP, CPR will now be called Basic Life Support (BSL) and the name of the program will be called 'CPD Program'.[6] The burdensome part not only involves part-time doctors having to fulfil the same criteria, but also that the requirement that CPD Category 1 activities must be conveyed to the RACGP as demonstrating that the activity chosen shows how the activity engages, reflects and reinforces the continuing development of the skills relevant to each practitioner's individual practice, which the RACGP will provide feedback on.[7]

Now the MBA has an opportunity to solidify the goal of patient protection by reconstructing the CPD. This is extremely important as the GP population is aging and those GPs who were previously unaccountable with regards to patient care need now accept that General Practice is a specialty in its own right. Foreign GP training programs and their own educational and CPD-like programs may be vastly different to Australia's and it is important that patients in Australia be afforded protection no matter who they consult. I will focus on accountability mechanisms which I feel need to be addressed to ensure that a proposed CPD starting in the 2022 triennium brings all GPs and specialist practitioners in Australia up to a standard that patients deserve. A current proposal exists for the 2022 triennium.[8] However, I do not see that this is vastly different to the current CPD criteria. The feeling by Australian GPs is that

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[3] Michael D Bollen, 'Recent changes in Australian general practice' (1996) 164(4) *Medical Journal of Australia* 212-15 < https://www.mja.com.au/journal/1996/164/4/recent-changes-australian-general-practice>.

[4] RACGP, 'QI&CPD Program: A guide for all providers of accredited activities' < https://www.racgp.org.au/FSDEDEV/media/documents/Education/Professional%20development/QI-CPD/QICPD-Guide-for-all-providers-activities.pdf>.

[5] RACGP, 'Provider framework for the CPD Program 2020–22 triennium Consultation paper for education providers' (2019) < https://www1.racgp.org.au/getmedia/6cb7a8f7-3104-4ad8-b158-551ee3b62f23/20784-CPD-Consultation-for-education-providers-V11_2.pdf.aspx>.

[6] Ibid.

[7] Ibid.

[8] Ibid.

it will be time consuming and not add value to their practice.[9] I also do not believe that it will shift the 'Bell-curve' of 6% of GPs behaving poorly with regards to patient protection.

History of the Medical Board of Australia's Professional Performance Framework:

Introduction of the CPD:

Vocational registration of GPs began in 1989 whereby doctors entering general practice needed to not only train and qualify to become a GP, but also commit and prove that they are involved in continuing education.[10] Prior to this, doctors who did not want to specialise in a particular medical field automatically defaulted to general practice. When vocational registration (VR) was introduced, it was not compulsory and those that were non-VR attracted less of a Medicare rebate.[11] VR is still not compulsory but GPs who have VR are listed as being a 'specialist' in General Practice on the Australian Health Practitioners Regulation Association (Ahpra) register.[12] A 'grandfather' clause existed by which doctors working in general practice at the time of establishment of VR did not have to sit the Fellowship exam of the Royal Australian College of General Practitioners (RACGP), but in order to continue to attract a higher Medicare rebate, had to fulfil CPD requirements.[13] In 2018, 36% of GPs were over the age of 55.[14] The 'grandfather period ended in November 1998 and all those wanting to have VR would either have to sit a Fellowship exam via the RACGP or the Australian College of Rural and Remote Medicine's (ACRRM).

Regulation of practitioners via the CPD:

In the 2011 to 2014 triennium, there was a drive by Ahpra to establish national consistency with regards to standards of practice and processes by GPs as well as accountability by

[9] Dr Isis Maitland-Scott, 'Why the new CPD plan makes my heart sink' (7 January 2020) *AusDoc.PLUS* < https://www.ausdoc.com.au/opinion/why-new-cpd-plan-makes-my-heart-sink>.
[10] RACGP (n 5).
[11] Quality Practice Accreditation, 'Vocationally registered GPs' < https://files.gpa.net.au/resources/QPA_Vocationally_registered_GPs.pdf>.
[12] RACGP (n 1).
[13] Quality Practice Accreditation (n 11).
[14] RACGP (n 1).

decision-makers for their decisions.[15] Under Part 2(6) NL, the Victorian Civil and Administrative Tribunal (VCAT) is the designated tribunal for hearing disputes by health practitioners regarding Medical Board decisions against them. The National Registration and Accreditation Scheme Strategy 2015-2020 has, as its 'vision', a goal of establishing a 'competent and flexible workforce' with regards to general practice, and a 'mission' to protect the public by regulating health practitioners efficiently and effectively so that the public can access safer health care.[16] The outcome would be to ensure that all GPs were trained and qualified to a standard, nationally, so that public confidence and safety would be enhanced.[17] The proposal involves undertaking a minimum of 50 hours per year of accredited CPD activities, with at least 25% to be taken as an educational activity; at least 25% would involve reviewing the GP's performance; at least 25% would be allocated to measuring patient outcomes and the rest of the 25% would be any accredited CPD activity.[18]

Currently, GPs have to provide evidence of attendance at RACGP accredited educational meetings or performing patient audits, having the National Prescribing Service (NPS) attend small groups (to pass on what current practice of evidence-based medical treatment involves) or participating in on-line modules. It has always been my concern, as I have seen for myself on virtually every occasion that I have attended pharmacy driven (but still accredited) meetings or day-long or weekend conferences, that attendance at these venues does not extrapolate into learning objectives. GPs fall asleep, look continuously at social media on their mobile phones or, in the case of the longer conferences, register at the conference and then leave, giving their colleagues permission to sign on for the modules on behalf of themselves. It is only the NPS meetings and on-line learning activities that ensure adequate learning and professional development occurs. Even attendance at current small group intra-practice meetings does not ensure adequate professional development as there is little evidence that practitioners actually understand what is being discussed – only a cursory meeting at the end of the year to discuss the modules covered is required. Still it provides no accountability for learning and professional development. My proposal hopes to change all this.

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[15] Ahpra & National Boards, 'National Registration and Accreditation Scheme Strategy 2015-20' (17 October 2017) < https://www.ahpra.gov.au/About-AHPRA/What-We-Do/NRAS-Strategy-2015-2020.aspx>.
[16] Ahpra & National Boards (n 15).
[17] Ibid.
[18] Medical Board, Ahpra, 'Registration Standards' (2020) < https://www.medicalboard.gov.au/Registration-Standards.aspx>.

Influence of practitioners by the pharmaceutical industry:

Prior to the accreditation criteria that had to be fulfilled by pharmaceutical companies to attract CPD points for GPs attending clinical meetings, GPs were entertained at very expensive venues and given drug-branded gifts to remind them to prescribe, and feel obliged to prescribe, the specific medication. I have attended lavish events such as the launch of a particular drug at the National Gallery of Victoria's main hall to view the latest Turner exhibition. This has now changed and medications in accredited meetings are not specifically mentioned, but are still talked about by the pharmaceutical representatives informally whilst doctors are having their meals and promotional materials are still sighted on tables outside the venues. The University of Queensland, led by Dr Geoff Spurling, performed research into relatively recent prescribing habits of doctors attending clinical meetings and the research found that attendance at these meetings did not promote or improve the 'quality of prescribing', but that GPs did tend to prescribe the drugs that were connected to the pharmaceutical company sponsoring the meeting, even if that drug was at a higher cost and potentially a lower quality than medications with evidence-based value.[19] A study done by Fabbri et al[20] between 2011 and 2015, suggested that the disclosure provisions mandated by the Australian Competition and Consumer Commission (introduced in 2015) no longer required the reporting of payments by pharmaceutical companies for food and beverages provided to doctors when detailing their products, leading to a lack of transparency. The study commented on the Open Payments database employed in USA which include any type of meal provided to doctors be disclosed as this was shown to have influenced increasing prescribing of costly brand-named medications.[21] This practice is now disallowed in many medical institutions, such as the University of Michigan, as it is thought to influence trainees 'from the ground up'.[22] The continued practice of allowing CPD point allocation to pharmaceutical company sponsorship is, therefore, affecting the impartial evidence-based prescribing of medications to a public which should be provided impartial health care to best address their health issues.

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[19] Ray Moynihan, 'Australian doctors get a massive dose of marketing', *Sydney Morning Herald* (11 July 2017) < https://www.smh.com.au/opinion/australian-doctors-get-a-massive-dose-of-marketing-20170710-gx8b30.html>.

[20] Alice Fabbri et al, 'A cross-sectional analysis of pharmaceutical industry-funded events for health professional in Australia', (30 June 2017) *British Medical Journal* < https://bmjopen.bmj.com/content/7/6/e016701.info>.

[21] Ibid.

[22] Ibid.

What constitutes 'good medical practice':

A code of conduct, *Good medical practice: a code of conduct for doctors in Australia*, was introduced in 2014[23] which sets out what is expected of GPs with regards to patient care. In particular, section 2 sets out what constitutes providing good patient care and section 3 establishes a meaningful doctor-patient relationship.[24] It is clear in the NL what constitutes 'unprofessional conduct' (Part 1(5) NL) and what constitutes 'unsatisfactory professional conduct' (Part 1(5) NL). It is suggested that approximately 6% of Australian doctors are performing to a poor standard, but that there is currently no accurate way to identify and predict the particular practitioner who is at risk of performing poorly.[25] Factors that may be associated with continual poor performance include older practitioners (especially those who are male), practitioners who have received multiple continuing complaints about their practice, practitioners working in relatively isolated environments and those with qualifications obtained in certain foreign countries.[26] It would be the aim of revised CPD programs to shift this 'Bell-curve' such that accountability via a CPD program would identify practitioners who pose a risk in these groups and educate and improve their quality of professional care of the public before mistakes are made.

S 8 of the Good Medicine Practice: A Code of Conduct for Doctors in Australia and the National Law:

There are still too many cases facing the Medical Board, the courts and tribunals where professional misconduct is the issue.

Section 8 of the *Good Medicine Practice: A Code of Conduct for Doctors in Australia* details what constitutes standards for appropriate medical practice.

S 8.1 states that practitioners should behave in a way that promotes trust and confidence by the community. This encompasses s 1.4 which states that doctors have a duty of care to place their patient's welfare first and foremost by being competent, truthful and compassionate.

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[23] Medical Board, Ahpra, 'Good medical practice: a code of conduct for doctors in Australia' (2019) < https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.
[24] Ibid.
[25] Joanna M Flynn, 'Towards revalidation in Australia: a discussion' (16 January 2017) *Medical Journal of Australia* <https://www.mja.com.au/journal/2017/206/1/towards-revalidation-australia-discussion>.

[26] Ibid.

This would no doubt ethically apply to disadvantaged patient groups. Dr Tolman was working in a hospital in Hobart when, in 2013, her conduct involving the treatment of 12 geriatric patients was brought to the attention of Ahpra. It was found that Dr Tolman had breached the *Good Medicine Practice: A Code of Conduct for Doctors in Australia*, s 1.4 (professional values and qualities of doctors), s 1.6 (relating to working with substitute decision-makers), s 2.0 (providing good patient care), s 3.0 (working with patients), s 4.0 (working with other healthcare professionals), s 8.4 (keeping adequate medical records) and s 8.8 (providing Medical reports, certificates and giving evidence). The Professional Performance Panel (initially referred to by the Tasmanian Board of the Medical Board of Australia) and later the Tasmanian Health Practitioner's Tribunal (in 2018, having been referred the case in 2016) determined that Dr Tolman should undertake an education program within 12 months and have her work supervised for 12 months.[27]

S 8.2 emphasises the need to maintain professional boundaries. Between 2012 and 2019 a patient and her psychologist alleged that Dr Al-Naser repeatedly kissed her and commented on his own and the patient's sexual conduct. The Medical Board immediately prevented him from treating female patients and prevented his daughter from working unsupervised as a receptionist at one of two clinics where Dr Al-Naser was restricted to work at.[28] Under s 156 NL, the Medical Board can take immediate action upon receiving notification if they reasonably believe that the practitioner's conduct, performance or health poses a serious potential risk to public health and safety. This action also contravenes Division 2 140(b) NL regarding sexual misconduct within the practice of the practitioner.

S 8.4 details that medical records are to remain accurate, up-to-date and securely held so that continuity of patient care be maintained. This was not the case with Dr Tolman as stated above.

S 8.5 states that practitioners are to maintain appropriate Medical Indemnity Insurance. In 2018, the MBA referred the case concerning Dr Bhamjee to the State Administrative Tribunal of Western Australia because Dr Bhamjee was practicing without holding current Professional Indemnity Insurance. He was fined $2,000 and had conditions imposed on his registration that required him to complete a program of education in relation to ethical

[27] Medical Board, Ahpra, 'Tribunal rejects medical practitioner's appeal against reprimand and conditions on registration' (25 October 2019) < https://www.medicalboard.gov.au/News/2019-10-25-tribunal-rejects-medical-practitioners-appeal-against-reprimand.aspx>.
[28] *Al-Naser v Medical Board of Australia (No. 2) (Occupational Discipline)* [2019] ACAT 110 (4 December 2019).

practice and professional obligations as a medical practitioner and he was ordered to pay the Medical Board's costs of $1,500.[29]

S 8.6 prohibits false or misleading advertising of a practitioner's professional capabilities, including avoiding inducements for testimonials on their behalf as well as not misleading the public with respect to falsely offering a future cure for illness. A Chinese medicine practitioner, Qi Xin Chen, did just this and was convicted on 31 October 2018 in the District Court of New South Wales and fined $45,000 (which was later reduced to $7,200 on appeal that the penalty was too harsh), and was also ordered to pay $5,000 to Ahpra for legal costs.[30]

S 8.8 prohibits a practitioner for being misleading when writing medical reports and certificates. Dr POS was found guilty by VCAT for not only providing false medical certificates to her employer, but also using colleagues' sick leave and falsely stating that she was suffering from breast cancer and needed treatment on those occasions when she had taken leave.[31] VCAT reprimanded Dr POS and placed educational and mentoring restrictions on her registration.[32]

Part 2 14(1) NL states that there must be approval to prescribe scheduled medications. Dr Wei Xiong Xie was referred by the Department of Human Services to Ahpra when they discovered that Dr Xie, between 2012 and 2014, was prescribing a drug of dependence, testosterone, to a patient at several times higher than the recommended dose and for no apparent clinical reason.[33] In 2017, Dr Xei was found guilty of these charges and fined $6000 and $7500 in court costs. In 2016, Dr Xei attended three educational workshops relating the prescribing of drugs of dependence, wrote a self-reflection on how this changed his clinical practice and he installed 'SafeScript' software to detect drug-seeking patients. This placated VCAT who was referred the matter by the Medical Board.[34]

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[29] Medical Board, Ahpra, 'Tribunal reprimands doctor for practising without professional medical insurance' (20 September 2019). < https://www.medicalboard.gov.au/News/2019-09-20-tribunal-reprimands-doc-for-practising-wo-prof-indemnity-insurance.aspx>.

[30] Medical Board, Ahpra, 'Appeal by Chinese medical practitioner against sentence successful' (28 March 2019) < https://www.chinesemedicineboard.gov.au/News/2019-03-28-Practitioners-appeal-against-sentence-successful.aspx>.

[31] Medical Board, Ahpra, 'Medical practitioner reprimanded for providing false medical certificates' (7 January 2020). < https://www.medicalboard.gov.au/News/2020-01-07-Medical-practitioner-reprimanded-for-falsifying-medical-certificates.aspx>.

[32] *Medical Board of Australia v POS (Review and Regulation) (Corrected)* [2019] VCAT 1678 (25 October 2019).

[33] *Medical Board of Australia v Xie (Review and Regulation)* [2019] VCAT 1924 (4 December 2019).

[34] Medical Board, Ahpra, 'General practitioner reprimanded for prescribing excessive amounts of testosterone' (7 January 2020) < https://www.medicalboard.gov.au/News/2020-01-07-General-practitioner-reprimanded-for-prescribing-excessive-amounts-of-testosterone.aspx>.

Part 2 6(1) NL prohibits conflict of interest with regards to a medical practitioner. Dr Cole had been referred to Ahpra, who referred the matter of unprofessional conduct of having a financial conflict of interest, to the Professional Standards Panel of the Medical Board. Dr Cole was found in breach of inducing a vulnerable patient who Dr Cole treated for chronic fatigue and who then coerced the patient to enter into becoming financially involved in the company, USANA products (from whom Dr Cole earned over $70,000 in each of the years of 2010 and 2011).[35] The Queensland Civil and Administrative Tribunal ordered Dr Cole to disengage from the USANA scheme for 12 months, reprimanded her and ordered Dr Cole to pay the Medical Board's costs.[36]

Part 1 5 NL defines 'professional misconduct' which is conduct by the practitioner that is substantially below what is expected of a practitioner of a certain level of experience. The MBA (Under s 190(b)(i) NL) referred Dr Christopher Kwan Chen Lee to the Tasmanian Health Practitioners Tribunal for online posts that constituted unprofessional conduct.[37] The tribunal concurred that the posts constituted unprofessional conduct and suspended Dr Lee for six weeks and imposed an educational activity involving 'ethical behaviour and communications'.[38]

With the current CPD recommendations in force, I do not feel that any of the above cases could have been avoided. Even with the proposed CPD changes, cases like these are still likely to happen. This is because practitioners are left to choose what educational activities they engage in and, clearly, in most of the decisions against the practitioners, further educational activities regarding breaches of the NL and Codes of Conduct were enforced. This does not shift the 'Bell-curve' of 6% of practitioners performing poorly and placing the public at risk. There needs to be a CPD program that forces medical practitioners to participate in educational activities that educate them in all areas of medicine in order to prevent misconduct from occurring. Many of the above cases took years to be adjudicated, allowing 'at-risk' practitioners to continue to practice unaccountably. Self-reflection obviously did not play a part in preventing adverse practices to occur and the self-reflection criteria in the current CPD would not make a practitioner honestly reflect on issues that were

[35] Medical Board, Ahpra, 'Queensland GP reprimanded after failing to disclose a conflict of interest' (18 June 2019) < https://www.medicalboard.gov.au/News/2019-06-18-Qld-GP-reprimanded.aspx>.
[36] *Medical Board of Australia v Cole* [2019] QCAT 113 (1 May 2019).
[37] Medical Board, Ahpra, 'Medical practitioner suspended for conduct online' (30 April 2019) < https://www.ahpra.gov.au/News/2019-04-30-medical-prac-suspended-for-conduct-online.aspx>.
[38] *Medical Board of Australia v Dr Christopher Kwan Chen Lee* [2019] TASHPT 3 (16 April 2019).

significantly left wanting. I also doubt that most Australian practitioners have read or are familiar with the NL or the *Good Medicine Practice: A Code of Conduct for Doctors in Australia.* This issue is not covered in the current CPD and should be.

Specific groups of practitioners over-represented in doctors who practice poorly:

Older medical practitioners:

As stated previously, there is a grandfather clause relating to admission into Vocational Registration of medical practitioners.[39] More than one third of full time GPs are aged over 55 and they are more likely to work more than 40 hours per week.[40] As the GP population continues to age and work, they are faced with age-related health conditions, such as dementia, and their valuable assets of knowledge acquired over the years and their ability to act as important mentors to younger GPs is said to be outweighed by having less factual knowledge, less ability to adhere to current and evolving standards of patient care and actually achieve poorer patient outcomes.[41]

The Expert Advisory Group (EAG) found that, as of March 2017, there were 5,596 GPs working over the age of 70 and 865 GPs working over the age of 80 in Australia.[42] The EAG advises that health and cognitive function needs to be screened regularly in practitioners over the age of 70 – this involves mandatory annual physical health checks and screening for cognitive decline in order to protect the public from potentially under-performing doctors.[43] This is reflected in s 9.2.7 of the *Good Medicine Practice: A Code of Conduct for Doctors in Australia*, where a doctor needs to consider whether they have an impairment that will adversely affect patient care, and s 9.3.3, where a colleague needs to either approach a GP whom they are concerned about their health to seek professional advice or mandatorily report this to the Medical Board.

[39] Quality Practice Accreditation (n 11).
[40] RACGP (n 1).

[41] Brian M Draper, 'Older doctors and retirement' (20 March 2017) 206(5) *Medical Journal of Australia* 202-3 < https://www.mja.com.au/journal/2017/206/5/older-doctors-and-retirement>.
[42] Medical Board of Australia, 'Expert Advisory Group on Revalidation: Final Report' (August 2017).
[43] Ibid.

Under ss 55(1)(a) and (1)(h)(ii) NL, a health practitioner may be judged as unsuitable to practice if they have an impairment which makes them unsuitable to keep the public safe with regards to their medical practice. Professor Ron Paterson details how 'Dr B', an elderly doctor who had been practicing for 50 years, did not maintain his clinical skills or maintain adequate computerised record-keeping, but chose to write hand-written notes that did not show evidence that he examined Mrs A or even formulated a diagnosis of her repeated lower abdominal symptoms that eventually proved to be a terminal gynaecological cancer which caused her to have her leg amputated prior to her death.[44]

In the UK, a case involving Dr Jagjit Singh Pawar, a GP who was working in the UK for over 20 years after graduating in India, was struck off after investigation by the General Medical Council (GMC) who received numerous complaints from employers and patients about his competency.[45]

I believe that the current CPD requirements do not adequately address uncovering doctors who have an age-related impairment as they will probably choose activities which they feel that they are currently competent in and self-reflection activities may only aid to revalidate their own feelings of competency.

Doctors receiving multiple complaints:

The EAG accepted the findings of a three-year study which showed that about three per cent of Australian doctors attracted nearly half of complaints made by patients and peers.[46] The EAG went on to encourage a pro-active approach by Ahpra and the Medical Board in identifying these practitioners as early as possible and potentially through the CPD program.[47] The EAG found that physicians who had obtained three paid claims against them were three times as likely (an absolute risk of 24%) to have another claim within two years and males over the age of 35 were much more likely than any other group.[48] Doctors just

[44] Ron Paterson, *The Good Doctor: What Patients Want* (Auckland University Press, 2012) 28-31.

[45] Clare Dyer, 'GP is struck off after a series of hurried and wrong diagnoses' (2016) 355(5676) *British Medical Journal* < https://www.bmj.com/content/355/bmj.i5676>.

[46] Bismark MM et al, 'Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia' (2013) 22(7) *The BMJ Quality & Safety* 532-540 < https://qualitysafety.bmj.com/content/qhc/22/7/532.full.pdf>.

[47] Medical Board of Australia (n 42).

[48] Ibid.

named in a third complaint had a 38% chance of receiving another complaint within one year and 57% likelihood of receiving a further complaint within two years.[49]

The GMC in the UK requires a formal scrutiny of a doctor's practice prior to re-accreditation and it is suggested that all Medical Boards should heavily scrutinize any doctor who attracts multiple complaints against them.[50] This is currently the practice at the *College des Medecins du Quebec*.[51] Professor Ron Paterson suggested that agencies dealing with complaints against medical practitioners should report all these incidences to the Medical Board and not simply those that are upheld in a formal investigation by a tribunal.[52] This sharing of information would have prevented the extreme harm to multiple patients over more than 20 years at the hands of Egyptian doctor, Emil Gayed.[53] The Medical Board of NSW did not share the Health Care Complaints Commission's recommendations of Dr Gayed being banned from performing microsurgery, undergo regular ophthalmic examinations or undergo a performance assessment.[54] The Board did not enforce mandatory reporting by Dr Gayed as to the hospital he was working at, in particular, Mona Vale hospital (which suspended Dr Gayed pending an urgent review by the Medical Board of his performance, which occurred one year later and which cleared him without having an ophthalmic assessment performed on him or observing him perform surgery), Dee Why hospital or Manning Base hospital.[55] The Medical Board of NSW did not respond to or share complaints made by the hospital boards, colleagues or patients about Dr Gayed's adverse patient outcomes or poor clinical treatment.[56]

Of the ten cases Ahpra investigated in 2019, which involved multiple complaints against individual doctors, concerns ranging from incorrectly prescribing medications, inappropriate or inadequate treatment or communications, inadequate record-keeping and reporting of adverse events, all received a caution or reprimand and five had conditions placed on their registration.[57] These doctors would most likely have been actively participating in the

[49] Medical Board of Australia (n 42).
[50] Ron Paterson, 'Not so random: patient complaints and 'frequent flier' doctors' (2013) *British Medical Journal* 22, 525-527 < https://qualitysafety.bmj.com/content/qhc/22/7/525.full.pdf>< https://qualitysafety.bmj.com/content/qhc/22/7/525.full.pdf>.
[51] Ibid.
[52] Ibid.
[53] Melissa Davey, 'Emil Gayed: damning report finds negligent doctor's privacy was put before public safety' (16 November 2018) *The Guardian* <https://www.theguardian.com/australia-news/2018/nov/16/emil-gayed>.
[54] Ibid.
[55] Ibid.
[56] Ibid.
[57] Ahpra & National Boards, 'Panel decisions' < https://www.ahpra.gov.au/Publications/Panel-Decisions.aspx>.

current CPD, but the CPD program was not sufficient to identify them prior to being reported. A revised CPD program should address evidence-based treatment currently expected of practitioners in all areas of medicine, which, I feel the proposed program will also fail to completely address.

International Medical Graduates (IMG):

Every year there is a growth in IMGs working as medical practitioners in Australia. There is a huge reliance by Australia on the IMGs filling voids in healthcare in rural parts of the country and in certain specialty fields such as Psychiatrists appointed to public hospitals. Whilst overseas-sponsored students will train, fully self-funded, in Australian Universities and obtain VR positions in the workforce, only about 50% of IMGs (in 2011) from non-English speaking countries will pass the Occupational English Test, which is the biggest barrier to fulfilling the preregistration exams. New Zealand trained doctors have a streamlined registration approval via the Trans-Tasman Mutual Recognition Arrangement. There is also a 'Competent Authority' option for doctors registered in New Zealand, the UK, Ireland, the United States and Canada which also streamlines their registration.[58]

IMGs seeking registration as a medical practitioner in Australia have to go through the Competent Authority Pathway (recognised by the Medical Board as having passed relevant medical courses in Canada, the United States, New Zealand, the UK or Ireland) and those not qualifying for this have to pass the Standard Pathway (or Specialist Pathway where relevant) which involves undertaking the Australian Medical Council (AMC) CAT MCQ (written exam) and an oral Clinical Examination. They will also have to work supervised in a hospital or in supervised general practice on a full-time basis in an AMC accredited service provider. Prior to this, all IMGs have to satisfy certain Registration Standards, including registering with the CPD, satisfying the Criminal History Registration Standard, English Language Registration Standard and the Professional Indemnity insurance arrangements.[59]

Satisfying these standards are essential to gaining registration as a medical practitioner in Australia. In 2012, Dr Cabading sought to renew his limited registration. However, the Medical Board refused his application as he had failed three attempts of the RACGP Key Feature Problems (KFP). Later, Dr Cabading sought re-registration through a different

[58] Lesleyanne Hawthorne, 'International medical migration: what is the future for Australia?' (29 October 2013) 199 (5) *Medical Journal of Australia* 18-21 < https://www.mja.com.au/journal/2013/199/5/international-medical-migration-what-future-australia>.
[59] Medical Board, Ahpra (n 18).

pathway via RACGP's Practice Based Assessment and he failed that as well. Ultimately, years later in 2016, the Queensland Administrative and Appeals Tribunal upheld the MB's decision, stating that Dr Cabading failed to prove that he could uphold the 'measurable standards for admission into general or specialist practice', so his name was removed from the register of practitioners.[60]

It is still of concern that people from overseas can slip through registration criteria and practice and obtain government rebates whilst not actually being doctors. Raffaele Di Paolo was working in Melbourne when he was found guilty of practicing as an unqualified medical specialist and charged with fraud, indecent assault and sexual penetration.[61] Sarang Chitale worked in public health in New South Wales for eleven years until, in 2016, his previous employer notified him to Ahpra who investigated his qualifications – he was, in fact, Shyam Acharya who had stolen the real Dr Chitale's identity.[62] No patient had actually complained about his treatment of them, and it was only after he was investigated that staff working with him said that his practice was sub-standard.[63] I asked a colleague, who is an examiner in the oral part of the IMG exams, whether he could tell if the person he is examining is actually the person stated and he said 'we don't'. The current CPD (and no doubt the proposed CPD) did not uncover these 'fake doctors'; it was only notification by patients who had suffered harm or an employer in the previous cases that these frauds were uncovered. My proposal for a revised CPD program should go further into protecting patients from these fraudulent people and actually prevent harm before it happens by having closer continuing contact with their peers.

Even if all the standards for entry into full medical registration are achieved, there is continuing scrutiny of performance via the CPD program. However, I feel that the current criteria, being almost entirely left to the discretion of the practitioner, will not uncover failings to the public and over-reliance on complaints by patients, employers or colleagues is still too heavily relied upon. There needs to be greater preventative measures to prevent public harm rather than after harm has been caused.

[60] Medical Board, Ahpra, 'Tribunal confirms Medical Board decision to refuse registration' (1 June 2016) < https://www.medicalboard.gov.au/News/2016-06-01-registration-refused.aspx>.
[61] Philippa Martyr, 'The fake doctors who get away with medical fraud' (10 April 2018) *ABC NEWS* < https://www.abc.net.au/news/2018-04-10/fake-doctors-medical-fraud/9634674>.
[62] Ibid.
[63] Ibid.

Solo, small group practices and isolated practices:

The EAG noted that professional isolation does not only occur in practitioners working in remote locations, but also those working in solo or very small group practices where they also tend to work for extended hours and have less of an ability to engage locums in order to take holidays or discuss particular patient issues with colleagues.[64] Not only do practitioners working in solo/small group practices and in rural and remote areas have higher rates of depression and anxiety, they are less likely to participate in national surveys relating to mood disorders suffered by themselves, are much less likely to be prescribed antidepressant medication and more likely to just be offered psychotherapy.[65] They not only work extremely long and concentrated hours, but they are more likely to fear physical retribution by patients due to their 'uncloaked' appearance in the local community.[66] Practitioners working in 'relative isolation' is a significant factor in the risk of poor performance with regards to patient care.[67] A grave example of such poor performance and lack of support to practitioners working in remote locations is that of the Inquest into the death of Jillian Peta McKenzie at the Queensland Coroner's Court (COR 2610/06(0)) where a major factor in Jillian McKenzie's death was that of a very junior unsupported doctor being solely involved in her treatment at Babinda Hospital and that the evidence showed that the junior doctor, Dr Lane, had not only no supervision but also no access to direct supervision.

Overseas trained doctors are also over-represented in the rural and regional workforce[68], making the potential for poor performance even more significant. Overseas trained doctors can attract Medicare rebate benefits under s 3GA of the *Health Insurance Act 1973* (Cth) when they are working in an approved training program or in rural practices or in practices which are deemed to be an 'area of workforce shortage'.[69] They have up to four years to

[64] Medical Board of Australia (n 42).
[65] Beyond Blue, 'National Mental Health Survey of Doctors and Medical Students' (June 2019) < https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web>.
[66] Ibid.
[67] Medical Board, Ahpra, 'New Professional Performance Framework for patient safety' (28 November 2017) < https://www.medicalboard.gov.au/News/2017-11-28-media-release-professional-performance-framework.aspx>.
[68] Belinda O'Sullivan et al, 'Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence' (22 January 2019) 17(8) *Human Resources for Health* < https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-018-0339-z>
[69] Australian Government, Department of Health, 'MORE DOCTORS FOR RURAL AUSTRALIA PROGRAM (MDRAP) GUIDELINES' (1 January 2019) < https://www.rwav.com.au/wp-content/uploads/MDRAP-Guidelines-V2.0-FINAL-1.pdf>.

successfully sit the RACGP fellowship exam and participate in CPD activities relevant to their practice.[70]

There are particular challenges faced by practitioners working in rural and remote areas of Australia. CPD activities and choices are quite limited due to ability to access the range of activities provided to more centrally located practices.[71] Practitioners are often left with on-line learning activities and, learning and updating procedural skills vital to the isolated work these practitioners do, is also very difficult to obtain.[72]

Recommendations for a revised CPD:

Factors that need to be considered regarding resistance to change by GPs:

Ahpra & National Boards posted articles on 26 November 2019 from the journal, Australian Doctor, stating GP's concerns about the CPD for the 2020 to 2023 triennium standards.[73] The overwhelming response was that the guidelines for 50 hours of CPD to be performed in order for a GP to remain registered with Ahpra, with a minimum of 12.5 hours dedicated to personal reflection on their own performance with regards to patient outcomes and at least 12.5 hours performing traditional CPD activities was inappropriate.[74] 93% of the nearly 800 individuals in a survey carried out by Australian Doctor replied that submitting a formal development plan each year to satisfy the CPD criteria would not benefit their practice as a GP.[75] The overwhelming belief was that the CPD stipulations were far too burdensome and the paperwork needed contributed nothing to knowledge and interfered with time that should be spent on actual patient care and it further led to a decrease in professional satisfaction.[76] It also poses a disadvantage to doctors who work part-time[77] whether they work part-time by

[70] Australian Government, Department of Health (n 69).
[71] Sarah Larkins and Rebecca Evans, 'Greater support for generalism in rural and regional Australia' (July 2014) 73(7) *Australian Family Physician* 487-490 < https://www.racgp.org.au/afp/2014/july/generalism-in-rural-australia/>.
[72] Ibid.
[73] Australian Doctor, National, 'Have your say: Is the board losing the CPD plot' (29 November 2019).
[74] Paul Smith, 'Reactions to the CPD shake-up' (29 November 2019) *Australian Doctor*.
[75] Ibid.
[76] Ibid.
[77] Kerry Breen, Greg Whelan and Katrina Watson, 'Changes to continuing professional development requirements for doctors need a rethink' (2019) <https://croakey.org/changes-to-continuing-professional-development-requirements-for-doctors-need-a-rethink/>.

choice, or they are heavily involved in running a complex household or if they are forced to work part-time as they are caring for a close family member with a disability.

Other concerns revolve around perceived personal attacks on their value systems with regards to patient focus in that GPs feel that they already self-reflect constantly regarding patient care and that the Medical Board is trying to 'micro-manage' them – but 'who controls the controller?'.[78] GP's opinion is that the Medical Board is influenced by politicians and bureaucrats but are not answerable to a higher legitimate power which uses evidence-based studies to determine guidelines.[79] There is a strong feeling that the current CPD will reduce the push to entice doctors to specialise in general practice.[80] This is reflected internationally, where accreditation and re-accreditation schemes are felt to place a much higher burden on appropriately performing doctors ('good apples') in order to prove that they are 'good', placing a higher burden on regulators in boards overseeing their practice and having complaints by the 'good apples' about the burden placed on themselves as well as the lack of efficacy of these programs.[81]

The current CPD criteria is felt to change nothing with regards to patient outcomes and doctors will waste valuable time 'jumping through loops and hoops' to satisfy the criteria without actually increasing their knowledge base.[82]

I have a concern regarding the broad concept of 'self-reflection'. Self-reflection on what? Doctors will self-reflect only on specific topics and, as general practice encompasses a huge range of clinical problems, I feel that this broad range will, in essence, be ignored.

Expert Advisory Group recommendations for a revised CPD:

Kaufman's principles of adult learning was cited in the Final Report by the Expert Advisory Group as being that 'adults are independent and self-directing; they have accumulated a great deal of experience, which is a rich resource for learning; they value learning that integrates

[78] Paul Smith, 'Reactions to the CPD shake-up' (29 November 2019*) Australian Doctor*.
[79] Ibid.
[80] Ibid.
[81] Shojania K and Dixon-Woods M, ''Bad apples': time to redefine as a type of systems problem' (2013) *British Medical Journal* 22, 528-531.
[82] Paul Smith, 'Board faces CPD backlash' (29 November 2019) *Australian Doctor*.

with the demands of their everyday life and they are more interested in immediate, problem-centred approaches than in subject-centred ones'.[83]

The EAG identified issues which a revised CPD program must address if, in the section titled 'Proactively identifying and assessing 'at-risk' and poorly performing practitioners', there is to be greater proactive protection of patients. These issues include:

1. Individual characteristics of practitioners including older age and those subject to multiple complaints.
2. Practice contexts with regards to isolated practitioners.
3. Health systems and culture which provides for the early identification and management of poorly performing practitioners, as well as sharing information about risk and identifying poor professional behaviour by doctors. This also includes remediation for poorly performing doctors and greater accessibility to patient outcome data.[84]

My recommendations for a revised CPD:

1. *An accredited CPR activity once for the triennium*.
2. *The triennium should be made up of 30 modules to be completed on-line* - each approximately 300 to 400 words.

- The modules would be based on a typical general practice scenario.
- The GPs completing the modules would be VR and non-VR GP's.
- How a GP should manage the scenario on evidence-based criteria and, where applicable, preferred treatment options. This would avoid writing about a topic and virtually copying and pasting RACGP or NPS standards of addressing a particular field of general practice.
- Of the 36 months in the triennium, the number 30 would allow flexibility whilst still ensuring that a GP's knowledge was enhanced and advanced.
- Each module would cover a full range of clinical concerns. E.g., Women's Health – the management of menorrhagia or, Paediatrics, an acutely febrile child or a child who is vomiting (including a focus on recognising and validating parental concerns).
- The case scenarios would be obtained from an accredited Australian University Final Medical Exam papers, so experts writing the questions would have already formulated

[83] Medical Board of Australia (n 42).
[84] Ibid.

a standard for passing the questions. This would be not only an effective means of engaging doctors in actively and effectively learning, but, as Kaufman, cited above, stated, 'they are more interested in immediate, problem-centred approaches than in subject-centred ones'. It would also ensure that GPs are up to the standard of recently qualified graduates. Above all, not only is this an efficient means of assessing up-to-date knowledge, but it would be resource-efficient and extremely cost-effective as assessors and case scenarios are already at hand.

3. *11 small group activities per year* – a minimum of 7 per year attended.

- Groups of practitioners would be formed on a voluntary basis – i.e., each practitioner would pick a group of practitioners they want to communicate and form a relationship with.
- Small group activities could be run within the practice, if large enough; practices could amalgamate to form a group, or each Division of General Practice could run monthly meetings where attendance could be in person or via a skype link.
- Each group activity would revolve around the 30 scenarios posted.
- The scenario to be discussed and analysed by the group would be posted on-line through the RACGP website at the start of each month.
- If a genuine reason for not attending the minimum of 7 sessions was formally given (e.g., travel or illness), then a replacement 40 category 1 accredited CPD activity should be undertaken, or the GP could tackle the case scenario outside of the group.
- The rest of the 3 modules to be undertaken for the year could be with the group or individually attempted by themselves on-line.
- The formation of these 'learning groups' would reduce isolation of GPs who would not normally network and they have the opportunity to get support from their colleagues. It would also encourage isolated or rural and remote GPs to have confidence in contacting colleagues who they become familiar with because of these forced learning activities in a group setting/environment.
- GPs attending these meetings would go through the allocated scenarios and this would make individual posting responses much easier.
- The meetings should run for approximately one hour, which would not be burdensome for most GPs.
- All GPs in the small groups would be encouraged to research the topic prior to the meeting and contribute on an equal basis. This would take the place of self-

determined educational activities, such as attendances at conferences where attention to the topic being discussed is not enforceable.

- There could also be a rotating format where a particular GP would thoroughly research the clinical problem scenario and present it to the group, and allow others to give feedback on their own research.

4. *Practice Accreditation to go beyond current criteria* - In the RACGP's Standards for General Practices, 5th edition[85], it is detailed how patient notes are to be kept and what are the important factors that should be considered when including details in patient histories. I have been personally involved in three accreditations of my own small General Practice clinic and have participated in accreditation of a large, multi-doctor clinic. When the accreditors visited the large clinic, I know that only one of the 17 GP's notes were heavily scrutinized. I wish to suggest that, when accreditors do the practice accreditation every three years[86], that the clinical notes of all the GPs of the practice be scrutinized with a view to remediation of practitioners who do not comply with the accreditation guidelines, which would amount to greater patient safety. This activity should also be included in the mandatory CPD requirements. This may increase the costs of a practice re-accreditation visit[87], but the costs would be borne by the practice owners (as is done so now and is tax-deductible), enforce that doctors working for the practice owner are practicing in a way that is beneficial to the practice as well as patients and would take the financial burden from individual GPs working in these group settings paying themselves for an individual practice review.
5. *Rural GPs* would still have to participate in an accredited emergency medicine module relevant to country practice, as is currently required by ACRRM.
6. *Part-time doctors* would undergo the same CPD criteria, but the once a month activity should not place an undue burden that they face by the current CPD proposals.
7. *Specialist medical practitioners* would be assessed by their relevant colleges in the same learning format. This would allow for a nationally consistent and accountable framework for all medical practitioners, and this is one of the recommendations by the EAG when it is written in their Final Report that 'The deliberate aims and high-level criteria for a nationally consistent approach to CPD for all colleges and providers

[85] RACGP, 'Standards for general practices 2019, 5th ed' < https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/5th%20edition/Standards-for-general-practice-5th-edition.pdf>.
[86] Ibid.
[87] Kerry Breen, Greg Whelan and Katrina Watson (n77).

needs to be clearly articulated. This will support collaborative development and maintain focus on the intended outcomes'.[88] I was talking to a fellow student who was also participating in the module I was enrolled in the Masters of Health and Medical Law at Melbourne University at the end of 2019. I asked this Urogynaecologist (who is working in Melbourne) why a specialist earning a significant income in private practice would agree to sessional work in a public hospital. He answered that his private practice is so repetitive and 'boring' that he needs to have contact with colleagues and other individuals. I believe that the relative isolation possibly faced in specialist practice would be addressed by attending monthly group meetings where clinical problems could be discussed in an informal setting.

Mandatory reporting of doctors and medico-legal aspects of practice that should be addressed in a revised CPD:

S 144(1) NL clearly states the grounds for which voluntary reporting of a health practitioner should be made. Part (a) is if the practitioner's conduct falls short of standards expected of their peers; (b) if their knowledge, skill, judgment or care is below an acceptable standard; (c) if the practitioner is not a suitable or fit and proper person to hold registration; (d) if the practitioner has a significant impairment affecting their skills; (e) if it is believed that a practitioner has contravened the National Law; (f) if a practitioner has contravened a condition of their registration and (g) if the practitioner is believed to be fraudulent. This section of the NL should be dealt with and explained in one of the study modules to reduce the potentially vague or uncertain aspects of it and makes the objectives of this NL section clearer to practitioners.

The barriers to reporting of health practitioners include being uncertain and unfamiliar with conditions regarding the legal requirement to report a suspect practitioner, a fear of retaliation by the reportee, a loyalty felt to exist between themselves and their colleagues and a lack of confidence that appropriate action would be taken when a report is made.[89] This topic should be included in one of the study modules.

[88] Kerry Breen, Greg Whelan and Katrina Watson (n 77).
[89] Marie Bismark et al, 'Mandatory reports of concerns about the health, performance and conduct of health practitioners' (2014) 201 *Medical Journal of Australia* 399-403 < https://www.ncbi.nlm.nih.gov/pubmed/25296061>.

Working within the framework of compulsory group meetings has the added advantage to the public of health professionals being able to more closely and consistently scrutinize the practices and attitudes of medical practitioners. In a study done by Dr Marie Bismark[90], of the 819 mandatory notifications made during the study period between 1 November 2011 and 31 December 2012, 62% related to 'perceived departures from accepted professional standards' of clinical care; 89% were nurse or doctor notifiers and 46% were from doctors other than the practitioner of concern's treating practitioner. The profession of the notifier was the same as the practitioner of concern in 80% of the cases. Employers of the health practitioner of concerned made up 46% of the notifications. These compulsory learning groups are therefore essential to the notification of Ahpra of practitioners behaving in a poor way and would greatly enhance the goal of patient protection before an adverse outcome arises.

All practitioners should take out Indemnity Insurance. However, most would not be aware of what their cover does not provide. For example, the Medical Indemnity Protection Society (MIPS) may not cover legal costs for representation of a practitioner alleged to be involved in sexual misconduct, significant discrimination against a patient or a practitioner not holding an appropriate training qualification or practising unsupervised whilst their registration requires them to do so.[91] Aspects like these should also be included within the modules I suggest.

Potential problems with my proposed format for a revised CPD:

Problems with the above format I propose include that large group meetings run over, say, weekends as is now done (for instance, focusing on Cardiology or Women's Health conference) may have greatly reduced numbers if my suggested revised CPD is implemented. However, accountability for learning at these events is currently not heavily scrutinized and, from my own experience, some GPs attend to sign up and acquire their CPD points but then leave the event. Incentives for attending these weekend conferences may have to be addressed by the convenors of the conference. For instance, staying at an attractive venue which would be tax-deductible or a subsidised discount for equipment purchased relevant to

90 Marie Bismark et al (n 89).

91 Ian Freckelton and Belinda Bennett, *Regulation of Health Practitioners, in Freckelton I & Petersen K, Tensions & Traumas in Health Law* Ch 37, 692-713.

that particular field addressed in the topic. There would be less attraction to attend pharmaceutical company sponsored meetings. However, this would be of benefit as stated earlier, according to Dr Geoff Spurling's research, that GPs did tend to prescribe medications made by the sponsoring pharmaceutical companies even if the medication was not evidence-based and at a higher cost than recognised evidence-based available medications.[92]

As with the potential ability for a GP engaging someone else to sit the IMG exams for them, there may be a possibility for a doctor other than the one supposed to be placing the on-line submission to submit a response. However, this would probably come with an expense to the fraudulent GP and this GP would still be exposed to, and probably learn from, a submission which addresses the core principles of good medical practice relating to the clinical problem-solving scenario. This would get far closer to a GP actively engaging in the relevant clinical concepts and accepted methods of evidence-based treatment than the current passive one of just having to attend a clinical meeting and just having their 'bums on seats'.

My proposed changes to enforcement of CPD:

Currently, if a GP does not meet the CPD standard, the Medical Board can either impose conditions on their registration, such as requiring compliance on the missing CPD requirement to be undertaken by a certain time-frame; the Board can refuse an application for renewal, under ss 82, 83 and 112 of the National Law, or can take action against the offending practitioner under s 128 of the National Law.[93]

My proposal for enforcement of monthly CPD requirements would encompass current National Law legislation but would be far stricter and more transparent in that any GP not fulfilling the monthly criteria of submission would be immediately notified and, unless there is a valid medical, psychological or hardship issue that prevents fulfilling the monthly criteria, their registration would be immediately suspended pending its completion. By potentially affecting a GP's earning capacity, they would be urged, on a regular basis, to comply with updating their knowledge more constantly than currently proposed and further establish General Practice as a serious and significant medical speciality. This would also

[92] Ray Moynihan (n 19).
[93] Medical Board of Australia, 'REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT' (1 October 2016) < file:///C:/Users/Leo/Downloads/Medical-Board---Registration-standard---Continuing-professional-development---1-October-2016.PDF>.

cover the recommendations by the EAG that, as Dr Flynn is cited in their Final Report, 'Trust and integrity are cornerstones of medical practice. Developing an approach to revalidation that is tailored to the Australian environment will help make sure that the trust and confidence the community has in the medical profession is well founded'.

Consideration of enforcement of GP standards overseas:

Canada:

Canada has a 'Maintenance of Certification'(MOC) program which runs for five years. There is a requirement to obtain at least 40 credits per year and at least 400 credits per five-year cycle with at least 25 credits in each of the three MOC categories – Category 1 being Group Learning activities; Category 2 being Self-learning activities and Category 3 being Assessment activities.[94] Canada recognises the importance of learning in a small group environment. However, only some provinces in Canada attract a site visit to scrutinize an individual practitioner's practice.[95]

UK:

The current re-accreditation of practitioners in place in the UK was fashioned after the Bristol Royal Infirmary Inquiry in 1996.[96] This case involves the deaths of children undergoing paediatric cardiac surgery without their parents being informed of the correct risk of death from the surgery performed by two surgeons in the hospital.[97] This was despite years of rallying by cardiac anaesthetist, Stephen Bolsin, to have the actions and competency of the cardiac surgeons investigated by the GMC and the Board of the hospital.[98] Finally it was

[94] Royal College of Physicians and Surgeons of Canada, 'Continuing Professional Development' (2020) < http://www.royalcollege.ca/rcsite/cpd/moc-program/cpd-activities-can-record-e>.
[95] Kerry Breen, Greg Whelan and Katrina Watson (n 77).
[96] Kamran Ahmed et al, 'The effectiveness of continuing medical education on specialist recertification' (July-August 2013) 7(7-8) *CUAJ/JUAC* 266–272 < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758945/>.
[97] Bolsin S, 'Professional misconduct: the Bristol case' (5 October 1998) 169 *Medical Journal of Australia* 370-2.
[98] Ibid.

decided that the Bristol case highlighted factors such as 'poor clinical teamwork, a severe lack of performance data, and an absence of reflective practice'.[99]

With the need to ensure that only competent health professionals are engaged to ensure public safety, the UK CPD program is composed of three parts, that of (1) mandatory recertification, (2) annual appraisal of doctors and (3) mandatory revalidation.[100] One CPD point is equivalent to one hour spent at a CPD activity and if the practitioner is able to show that the attainment of this knowledge directly relates to their specific practice profile, then this number is doubled.[101] There must be 50 CPD points attained each year and at least 250 points over five years to be revalidated.[102] It is interesting that the GMC does not place much time and expense in validating and accrediting CPD activities – it is left to the individual practitioner to source activities that are relevant to and bolster the effectiveness of their particular practice.[103] These activities can be anything from on-line learning activities, conferences (possibly pharmaceutical company sponsored) to visiting a higher educational or hospital facility.[104] They are encouraged to cover the key 'domains' of principles set out in '*Good Medical Practice Framework for appraisal and revalidation*' which include knowledge acquisition, skills and performance training, safety and quality assurance, communication (to patients and colleagues), partnership and teamwork and maintaining trust.[105]

Establishing a relevance to their particular practice and a huge component of self-reflection (including how the practice is running efficiently as a group with regards to patient care and safety) is required to be reported annually to an appointed 'appraiser' of their practice which uses the CPD component as only part of their practice appraisal.[106]

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[99] Institute of Medicine (US) Committee on Planning a Continuing Health Professional Education Institute, 'Redesigning Continuing Education in the Health Professions' (2010) *National Academic Press* < https://www.ncbi.nlm.nih.gov/books/NBK219811/>.
[100] Institute of Medicine (US) Committee on Planning a Continuing Health Professional Education Institute (n 99).
[101] Kylie Simmons, 'Continuing professional development (CPD) in the UK' (26 April 2018) < https://knowledgeplus.nejm.org/blog/continuing-professional-development-cpd-in-the-uk/>.
[102] Ibid.
[103] General Medical Council, 'Continuing professional development: Guidance for all doctors' (2012) < https://www.gmc-uk.org/-/media/documents/cpd-guidance-for-all-doctors-0316_pdf-56438625.pdf>.
[104] Ibid.
[105] Ibid.
[106] Ibid.

As patient protection-driven as the UK CPD seems, there is still concern that the activities undertaken by practitioners will be just 'bums on seats'[107] as well as having an undue influence placed on the practitioners by pharmaceutical sponsored clinical meetings.[108] I am also concerned that CPD activities are not scrutinized (as is done in Australia by the RACGP) by the GMC with CPD activities being undertaken by practitioners potentially being fettered as to their actual clinical content and what they intend the 'appraisers' to hear and believe occurred in these activities.

USA:

The Federation of States Medical Board oversees 70 medical boards across the USA. The basis for continuing learning is based on the *Code of Medical Ethics* established by the American Medical Association which attempts to ensure patient and public safety. Each board has re-registration periods that vary from one to three years and varies in the Continuing Medical Education (CME) credits expected for renewal of registration. Each board has the discretion to also require completion of CME courses that may not be relevant to an individual's practice, such as pain management. The Accreditation Council for Continuing Medical Education grants organisations Category 1 Credits and determines the standards of Category 2 CME Credits. Category 1 activities can involve analysis of a particular topic, analysis of deficiencies in their practice, implementation of changes that are uncovered by the analyses and then self-reflection on implementation and deficiencies in their practice. However, there are a number of other ways Category 1 activities which can be sourced, for example, by reviewing journal articles, publishing peer review articles and attending live activities, to name a few. Category 2 activities include a range of options like small group meetings, consultation with medical experts and research, to also name a few activities accredited in this category. It is still felt by practitioners that this format does place

[107] Dr Anshu and Tejinder Singh, 'Continuing professional development of doctors' (2017) 30(2) *The National Journal of India.*

[108] Tamara Allen et al, 'Framework for industry engagement and quality principles for industry-provided medical education in Europe' (16 May 2016) *Journal of European CME* < https://www.tandfonline.com/doi/full/10.1080/21614083.2017.1348876>.

undue burdens of 'cost, complexity, time commitments and effectiveness, on top of current demands on a physician in today's increasingly complex environment'.[109]

There is no uniform provision that I have found in the USA CME program that addresses scrutiny of individual practices on a regular basis.

New Zealand:

The Medical Council of New Zealand requires practitioners accumulate at least 50 hours of CPD per year which includes a clinical audit, 10 hours of peer review, 20 hours of CME and regular practice review.[110] Regular practice reviews are conducted by a practitioner's peers in a relatively informal way, with recommendations for improvement being conveyed to the practitioner.[111]

Strengths and weaknesses of overseas CME programs:

Whilst all of the above overseas CME programs strive to address patient protection (with key principles being continuing improvement of practitioner learning and education), scrutinization of individual practices and reduction in undue influence by pharmaceutical companies with regards to self-interest, I do not think that any of these models completely address the vital issues of improving the knowledge of practitioners with regards to the entire range of medical fields and patient scenarios within these fields that a General Practitioner may face. They also do not go far enough into assuring that a GP will not be unduly influenced by an external source with a vested interest. This is why I believe that my very simple model is superior, not only in acquiring knowledge in all fields of General Practice as well as specialty practice, but in assuring unbiased learning of evidence-based medicine and not placing undue burden of time of undertaking activities on the practitioner. My proposal also encompasses scrutinization of a GP's individual practice.

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[109] Alejandro Aparicio, 'Continuing Professional Development for doctors, certification, licensure and quality improvement. A model to follow?' (January-March 2015) 16(1) *Educacion Medica* 50-56 < https://www.sciencedirect.com/science/article/pii/S1575181315000108>.

[110] Kerry J Breen, *Revalidation – what is the problem and what are the possible solutions?* (17 February 2014) < https://www.mja.com.au/journal/2014/200/3/revalidation-what-problem-and-what-are-possible-solutions>.

[111] Medical Council of New Zealand, 'Policy on regular practice review' (26 October 2016) < https://www.mcnz.org.nz/assets/Policies/23319bbd6c/Policy-on-regular-practice-review.pdf>.

Conclusion:

I feel that my proposals for a revised and very different CPD program fulfils all the criteria recommended by the EAG's Final Report. It addresses the concerns and scrutiny of older doctors and those receiving multiple medical complaints by their peers in an informal but valuable setting of small group learning, which I have found is encouraged by all nations. It reduces the isolation of solo/small group and rural and remote practitioners and has the potential to improve the adverse risk that these isolated practitioners may face because of their isolation.

The current feeling by most General Practitioners are that the proposed changes to the CPD would not improve their practice and would be extremely time-consuming as well as detrimental to those practitioners working part-time and in rural and remote communities. The proposed CPD changes would reduce the attraction to join the General Practice workforce and would reduce a good life-work balance. My proposal would not be burdensome on a total hour basis of commitment to the CPD program; it would be extremely cost-effective and it would positively encourage learning about all areas of general practice and not just areas that a GP would be comfortable about learning. My proposal would remove the vague 'self-reflection' hurdle and self-reflection would be through formal responses to the submitted clinical case scenario work by the RACGP overseeing the online posts.

In most international countries, there is a goal to reduce pharmaceutical company sponsored learning modules to achieve less of a bias towards prescribing less evidence-based and more expensive medication. My proposed CPD format would achieve what no country is yet to achieve.

The focus of CPD should be on patient protection not only by newly trained GPs but internationally trained practitioners and GPs who are part of an aging population who were previously poorly accountable.

The enforcement criteria would be strict and be on *continuous* not a *continuing* upskilling of General Practitioners, which would greatly enhance public confidence and not have extreme delays in uncovering doctors that may be practicing poorly for years without having their practices scrutinized or undergoing remediation.

My proposed CPD would also address scrutiny of an individual practitioners' practice through practice accreditation visits.

Above all, as practitioners involved in learning in regular small group sessions are best placed to identify practitioners behaving poorly. This type of learning and scrutiny by peers would greatly benefit identifying poor quality practitioners *before* they have a chance to harm a patient.

General Practice is a specialty in itself and it should be treated as such by the College and all practicing GPs. It is vital for public confidence and public safety that a GP be made to be accountable for learning about all fields of General Practice on a continuing basis. The only and very simple and cost-effective way to achieve this is to consider and implement my proposed model for CPD.

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