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Consultation on revised CPD Registration standard – IN CONFIDENCE

We write in response to the Medical Board of Australia call for public consultation dated 13 November, 2019 on behalf of the Cardiac Society of Australia and New Zealand. The CSANZ strongly supports high quality CPD for all Medical practitioners.

We address specific points raised in the Medical Board communication, and raise several other matters which are important for the success and sustainability of planned CPD changes in Option 2- revised standard.

1. **The following comment has been extracted from the Medial Board communication**: While some medical practitioners would need to review their CPD arrangements and practices, the requirements are expected to have a minimal regulatory impost as the majority of practitioners already co-ordinate and manage their CPD through an organisation such as a specialist medical college or other organisation. These organisations have been updating their CPD programs in recent years to reflect contemporary understandings about high quality CPD. Therefore, the costs of the preferred option will be minimal and limited.

This assumption is clearly incorrect for the vast majority of Cardiologists, especially for those who work in Private Practice in Australia. The current RACP CPD program is effectively a holding site or data depository for accumulated educational activities. Recent modifications to change the domains within the website attempt to align with the new headings of performance review and outcome measurement do not change the primary role as data repository. At this time, there is no mechanism for any Cardiologist to avail themselves of tools for performance review or outcome measurement unless they are substantially appointed to a major teaching hospital. Even there, significant changes to data collection will be required as there are no national registries for benchmarking performance in the major outputs of clinical cardiology (perhaps surprising, but true). We have discussed the English evaluation framework with UK colleagues, and their approach is heavily linked to the reporting framework within the NHS. As this does not exist in Australia, shortfalls in our current governance frameworks will need to be anticipated.

Surgical and non-surgical procedures avail themselves more readily of immediate and 30- day outcome data, and acquisition of such data is feasible. However, peer review of such data requires new systems and processes which will need to be funded and resourced with suitably skilled and credentialled groups. Within the Speciality of Consultant Physicians, craft-group specific expertise (eg Cardiologists for Cardiologists) would be needed, and these would need to be accessed via the special societies, for example Cardiac Society of Australia and New Zealand (CSANZ), or via new privately funded commercial entities as exist overseas. Credentialing, performance review and auditing of CPD are resource intensive

to be performed adequately, and new avenues for Special societies to be funded to perform these tasks would be needed. Expensive subscriptions to the RACP, which are currently mandated to maintain "Specialist" or " Consultant" status should be redirected, at least in part, to those craft group organisations that will perform the critical evaluation procedures. Otherwise, privately funded, for profit entities will be established to provide services missing. These organisations would then need to be credentialed to avoid rogue or meaningless evaluations.

The problem is even more serious for non-procedural practitioners in private practice (and we suspect relevant to the majority of non-procedural physicians). How can a private Cardiologist in rooms, audit the outcome of patients treated for heart failure or hypertension? Data registries, agreed evaluation frameworks, meaningful outcome measures that are beyond reproach would need to be provided, the database populated by a paid data manager, and an independent reviewer paid to assess and report on the outcomes. Critically, outcomes need to adjusted for patient demographics and comorbidity. This is because between hospital variation in outcomes after common cardiovascular conditions tracks with differences in patient comorbidity, and this will also apply to the community practice setting. This has never been systematically achieved in Australia for inpatient hospital admissions for these conditions, let alone for community practices. At this time the RACP has not engaged with the CSANZ to help develop craft group specific outcome measures or performance reviews, and the RACP home remains a CPD depository. Consequently, much work needs to be done before the current RACP CPD can be considered fit for purpose to align with AHRPA's priorities.

We recommend that practical solutions be provided to the medical community to facilitate the collection of relevant data, that formalised networks of credentialing groups be established, ideally under the auspices of respected special societies, or other professional organisations. Funding for these processes should be carefully thought through. Timely anticipation of these problems will make the achievement of meaningful CPD much more likely.

We now refer to specific items in the call for responses.

1. No, the new standard is less workable than the current standard.
2. The new standard should not be introduced unless clear frameworks are established for the collection of data, the review of outcomes and audit, as indicated in comments above.
3. Clear guidance as to who can perform audit and review, and what credentialing is needed.
4. See above.
5. Agree
6. Agree Interns can be exempted.
7. Specialist trainees should be covered by their training program. I (LK) have chaired the ATC in Cardiology and this is extremely demanding. Additional CPD is superfluous.
8. IMGs should complete CPD in addition to their training program. This will make their transition to the general workforce, and expectations of lifelong CPD, easier.
9. Exemptions are reasonable. These should be granted by the CPD provider/CPD home.
10. This is extremely challenging and unworkable. It will mean separate sets of CPD for each hospital or practice which will treble the cost, workload and seriously undermine the feasibility. It is reasonable that the CPD should reflect performance relevant to a substantial/major part of the Cardiologist's practice. But a single CPD completion should be needed for each practitioner.
11.
    a. Yes.
    b. No. We agree that educational activities are reasonable as we all need to keep up to date, but performance review and audit is meaningless for those who do not include direct patient contact.
    c. Direct patient contact is a reasonable delineator. The CPD home could request clarification as to why the practitioner considers themselves exempt. Having the CPD home do this would allow a more nuanced and craft group-relevant understanding of when exemptions could occur than if the Medical Board did this.

12.
    a. It is clear, but it is clearly unworkable.
    b. The principles for CPD homes are helpful but only partially relevant and unworkable as they do not address the key issues of data collection and review.
    c. Annual compliance is reasonable.
    d. 6 months after year's end is reasonable.
    e. Between 1-5% is reasonable. We have no knowledge from overseas data on this.
    f. The CPD homes should have clear policies for communication, explanation and provide guidance to the medical practitioner as to where they fell short. They should allow resubmission of deficient data to minimise formal reporting to medical Board and to avoid formal censure. The CPD home will need clear legal frameworks in case of legal challenge.
13. Absolutely, but with explicit input from Special Societies such as the Cardiac Society. The Specialist Colleges- but more particularly the Special Societies- are the groups with knowledge. A Paediatrician Cardiologist will not be able to comment on the appropriate measures for an Adult Oncologist, and neither can the RACP do this for the whole of Internal Medicine while representing everything from Paediatrics to Occupational health to Cardiac electrophysiology. A non-procedural Physician should not be setting the standards for a Surgeon or vice versa.
14. The key is establishing workable frameworks. Having data depositories is not the issue- data collection, audit and their funding is the issue. I think it would take at least 3 years to do this. It could take less if less ambitious types of review were expected.

We would be delighted to work with the Medical Board to facilitate the enhancement of CPD in Australia and would be very happy to meet face to face if this would be considered helpful.

Yours sincerely,

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