Submission from Dr Jennifer Anderson to Public consultation on Draft revised *Registraion standard: Continuing professional development*

To Whom it may concern,
Thank you for the opportunity to provide a submission to the "Draft revised *Registration standard: Continuing professional development" public consultation* that commenced on 13 November 2019. Thank you also for extending the consultation time to beyond the Christmas and school holiday period.

Personal Background
As background to my situation I work part time (2 days a week) as a GP in a medium sized non corporate multidisciplinary practice in the centre of Melbourne. I specialise in Pre pregnancy planning and pregnancy care and choose to work part time due to other commitments in my life, both within and outside of medicine.

I graduated over 25 years ago, entered the General Practice training program run by the Royal Australian College of General Practitioners (RACGP) on completing my hospital intern year, and have also worked in the past for over 10 years 2 sessions a week in a hospital setting.
During my time as a GP I have worked in various settings; rural, regional and metropolitan, small group practice, solo, aboriginal health centres and in the United Kingdom for a few years. I have also contributed to various advisory committees and recently commenced on the Victorian RACGP Council. I have spent one year on a Primary Health Network board. This submission is my own thoughts and does not necessarily reflect the thoughts of any organisation I am associated with.

Current Practice Setting
Where I work practitioners include physiotherapists, nurses, dieticians, masseurs, exercise physiologists, medical specialists other than General Practitioners, audiologists and psychologists.
We encourage multidisciplinary learning within our practice, and a variety of professional development opportunities outside our practice, sharing what has been useful and not so useful. I feel fully supported in my practice to either find my own professional development activities, many of which I attend with my fellow practice GPs, and our practice also provides us with professionally run continuing professional development (CPD) available to any practitioner of any discipline at the practice. These in-house programmes are of high quality and reflect what practitioners have asked for, and the nature of our practice. We always reflect on each session to determine what we have learnt, how we may change or prescribing or referring practices, and what the quality of the session was like. Even a lower quality educational session provides us with intelligent reflection and discussion.

Commentary on The Expert Advisory Group on Revalidation Final Report August 2017 and Consultation paper format
Before commenting on the proposed changes to CPD I would like to comment on the process of public consultation and exploration of ideas thus far.
The reading material provided regarding the draft proposed changes was in a format that was not user friendly. It was quite long and repetitive, and on many occasions did not clearly

define what you were talking about until well into the document, and sometimes not fully at all.
The background reading of the Expert Advisory Group's (EAG) reasons for recommending these changes to the Medical Board of Australia (MBA) was even longer and also repetitive. It lacked evidence behind many proposals and often had superscript numbers without any notations at the bottom of the page being provided.
Many of the documents referenced were written many years ago, including 2005, 2007, and 2009. The work from Klass was written up in a journal in 2007. Is this still relevant today 13 years later?
Given the time it takes between researching and publishing a document, I am unsure whether using such old reference documents would constitute current best practice.
Given a review of continuing professional development had occurred only 18 months earlier I would question the motivation behind the need to review it again so soon.
I also note that there does not appear to be any clinically practicing General practitioners on the EAG, and no representation noted from part time practitioners.
I do not recall any consultation prior to this current paper we are being asked to comment upon and am unsure how widely publicised the opportunity to comment was.

Doctors are busy people, who already spend a great deal of their day on non-clinical care. To add on top of this reading your 50-page public consultation document, and associated background documents, was quite a challenge.
Please remember that doctors are not "Board members" and the professional development needs and self-assessment that is applied in the corporate world or even not for profits of boards is not applicable to individual practicing doctors, who are time poor already with the amount of documentation and paper work required, that either takes time out of their clinical time or personal time.
I have read both documents and provide the following comments.
I will not be following the 14 questions asked, as again I feel they are quite repetitive, and I am not sure they add value to my submission.

CPD Homes
My biggest criticism would be the use of the term "CPD Homes" as it is not fully outlined in the document. It is poorly described, such that even by the end of the document I was unsure what a CPD home was, what its role was, and how I would determine which, or how many "CPD Homes" would be right for me.
How will a "CPD Home" be accredited? What fee will it charge me for the service? Will it align with the principals of my specialist college and the other colleges under which I have taken further qualifications?
How will doctors know which "CPD home" has adequate accreditation for their needs, and will be able to contribute to what is appropriate CPD for them?
Who will determine what a doctor's "scope of practice" is in order to determine a relevant "CPD home"? How will I know that the CPD home is not simply set up to make a profit for itself, rather than look after my best interests and that of patient safety through good quality professional development opportunities?

My primary specialist qualification is that of a GP, but I also have a Diploma Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG), which requires

me to be reaccredited currently every three years, which I do via gaining adequate women's heath points to an appropriate standard determined by that college, via the RACGP, who currently administer my point system. I am also required to gain enough accredited points to be able to continue providing Shared maternity care at various hospital in Victoria.
The current reporting system works well.

I can see no evidence provided that the system we currently have is not producing adequate professional development for doctors or compromising patient safety.

Any system can always do with improvement but the changes you are proposing seem rather time burdensome for already time poor doctors, with no evidence that they will be any better than the system we currently have.

I have no issue with other accredited providers being able to administer a point based professional development system, as long as I can be assured, they have no conflict of interest and provide me with full access to a variety of CPD opportunities.

I am opposed to having to have more than one provider or "CPD Home" administer my points, as the current system where RACGP provides RANZCOG with the evidence I have attended appropriate activities, and the hospitals I perform Shared care for with similar evidence, is efficient and simple. I am not aware of hospitals, RACGP or RANZCOG being dissatisfied with the current system.

For a few years I registered with both Australian College of Rural and Remote Medicine (ACCRM) and RACGP, as I was not happy with the RACGPs introduction of the overly burdensome PLAN. It took a long time to complete both at its initial set up but also in recording against it, so I wished to consider another service provider.
I found having two points accreditors difficult as professional development providers could only cope with one registration number, meaning you had to self-report to the other accreditor. For this reason, I am now only a member of RACGP who administers my points.

From my understanding the CPD home will accredit my points for the Medical Board, but my specialist college may require a different reporting system.
Whatever system is development it needs to be seamless such that there is only one reporting mechanism and time period required.

Annual Accreditation rather than a triennium
As a health professional I have the intellectual capacity to determine what type of professional development is appropriate for me in any particular year, depending upon my needs.
Some years I may pursue a certain new area of interest, depending upon where I or my practice identifies potential gaps may be.
Other years due to larger commitments outside of my clinical practice, I may simply want CPD that ensures I remain up to date with the core business of General Practice.
This is why a three-year accreditation period works so well.

If the accrediting period changes to yearly it will not only be overly burdensome for busy health professionals, but also for the colleges or “CPD homes” that are charged with administering the points.
The writing of the initial plan, assessing it personally at the end of the year, submitting it to the CPD home in enough time to have it processed to then be able to commence the following years plan would mean a lot of time would be spent administering the system, rather than actually providing professional development.

With the three-year system we are currently on it allows for flexibility of situations.
It particularly assists female GPs, who more often than male doctors, have other functions outside of the workplace as primary care givers for children or parents.
Some years these care giver needs may mean limited clinical practice, and thus less time for professional development. Professional development needs also change when you are practicing less, or in a different way.
Most clinicians would then be able to catch up on their points when they are in a position when they have more time or are practicing more.
Maternity, carers and sick leave are particularly an issue for a 12-month system, but less so in a three-year system, where it is often appropriate to catch up on what you have missed during your time away from clinical practice.
If a doctor has to apply for special circumstances each time, they have a baby, or provide care to a sick loved one, this would seem overly burdensome in a time that may already be causing external stress.
The three-year period gives them time to possibly do some professional development from home whilst on leave, and then determine once back in practice where their gaps are and what they may wish to engage further in to improve their knowledge since they look leave.
Good professionals would limit their clinical practice at times of poor mental or physical health, and at this time may also not be in a position to perform professional development.
The three-year system gives them comfort that they can get healthy again, to complete professional development needs during the times they have better health.
The thought of having to determine their needs in advance, and to meet them and report on them every year, may result in unnecessary stress, and a reluctance to continue in clinical practice.

A GP may notice a gap in their knowledge and decide to learn about a particular topic. It may be that in the particular proposed year of accreditation they do not actually come across this clinical situation again to know if their educational activity resulted in a changed outcome of practice. At least in a 3 year accreditation period they are more likely to encounter the situation again to use what they have learnt.

Some professional development, particularly audits and research, will clearly take more than one year. It may be difficult to assign points to such work until it is completed, thus a doctor is working on professional development appropriate to their scope of practice, with a high level of learning opportunity, but will be unable to attract points for it until perhaps the second or third year of the project. They should not have to do other professional development on top of this simply to gain the required annual points. A three year system is thus more appropriate to encourage more research and auditing to occur.

Loss of Self-Directed Learning
Self-directed learning is an important part of the mix of professional development, and in many cases may be more accessible, collaborative and relevant to a doctor's scope of practice. The current onerous bureaucracy in getting a course accredited often restricts providers of education from formally applying. This does not make the educational component any less worthy. Hospitals are particularly vulnerable to not having GPs be able to self-record their points, as they often have small teams who run the events, with limited funding, as they avoid potential conflict of interest sponsorship, which larger companies who provide professional education may not do.
Self-accrediting points allows doctors to attend smaller professionally run events or online courses in situations where they may not have the time, finances or capacity to attend or participate in larger courses that are more able to be provided by a limited number of large organisers, who obtain possibly conflicting sponsorship, and can easily administer event fees.
Currently most CPD accreditors are specialist colleges, who interact with their members frequently to determine their needs. The appropriateness of educational activities already comes under scrutiny, and in many cases, such as RACGP, the amount of unaccredited or self-directed learning points allowed is limited to allow for flexibility but also accountability. This ability to self-accredit some of doctor's professional development needs should not be lost.

Assessment of doctors over 70 years of age
The proposal to "screen" every doctor once they turn 70 is not realistic, and is discriminatory.
Who pays for this health check? What is the insurance or income protection implication of it? How can it be guaranteed to be confidential? Who will provide the assessments?
The arguments raised for age screening of potential cognitive decline or not knowing about the latest medical advances can occur at any age and no evidence is provided as to why age 70 is the most appropriate age to screen. There already exist mechanisms by which doctors can self-report issues of concerns about themselves or others capacity to practice, which should be enough to ensure competency of practice can occur at any age, in a supportive, non-discriminatory manner.
As there are already systems in place to investigate further fitness to practice based on past findings of poor practice, this age-based assessment should not be included in this revalidation document.

The three types of learning
Neither document demonstrates evidence that the current methods of accrediting doctors have resulted in poor quality of doctors.
As far as I am aware the RACGP CPD programme is highly acclaimed.
The proposed system at best results in an increased time spent in the administrative part of the program rather than clinical practice or the actual education itself, and at worst education designed and accredited by those who may not understand the diverse and flexible needs of the medical workforce.

25% on activities that measure outcomes

Some doctors have a particular area of interest within their specialty area. Their professional development therefore may simply be to keep up to date with this area, and if they remain up to date the outcome may be that nothing changes. This is not necessarily a bad thing. The outcome is that they remain up to date, but how would this be measured?

All professional development should have the outcome of remaining up to date, improving knowledge and ensuring safe patient care.
The activities provided as examples of measuring outcome activities may not be readily accessible to many practitioners, particularly solo practitioners, and may not be able to be achieved within an annual reporting period should the Board choose this.

The documents do not outline how these "outcome measures" will actually be measured. Without this information it is difficult to agree to the changes.
Audits and quality improvement projects are the easier forms of professional development to provide outcome measures for, yet it is unlikely many of these would be able to be completed in a 12-month period.
If doctors are already proving data to external providers for analysis, they should be provided with points accredited to their professional development for doing so once the data is reflected upon. Again, this may not necessarily occur in a one-year period.

Examples given in this category seem somewhat limited.

25% that review performance
The 25% "review performance" CPD seems out of step with what doctors actually do. We are not a board of directors who work collectively and should assess this. We practice independently and self-reflect on every consultation. We professionally consult and discuss issues with our colleagues, both medical and non medical on an almost daily basis. This should not have to be "formalised" via an accredited activity designed by another provider. Each specialty college already encourages practices and practitioners to perform self-reflection and peer review in a less formalised way, and most doctors already undertake this activity as part of normal practice every day. Adding a reporting component to it is an extra burden.
If this was able to be self-recorded without too much effort then this may be of benefit as it would be a simple way to record what is already occurring.
Professional development plans should be optional.

25% on educational activities
All activities undertaken for professional development should be educational, so I am not sure what this category achieves as a separate category title.

Personal professional development plan
I have already commented on this in the CPD home section and three year versus annual accreditation but will expand further here.
If the system of accreditation/ revalidation is to be run on a yearly basis and required a compulsory professional development plan each year, the plan itself may take up more unnecessary time than the learning goals the doctor is trying to achieve.

Doctors are continually identifying gaps in their knowledge, or areas of expertise they wish to explore further, and this may not be evident at the beginning of each year.
If at the end each year this professional development plan must be reported against, this again takes up a doctor's time, with potentially limited benefit.
The administrative burden of the provider who accredits the points and the plan is also increased, given the doctor will need to have reflected on the prior year's plan, reported back on it, and had it signed off my their "CPD home" before they can complete their next plan. If the "CPD Home" is allowed 6 months to report back on the previous year's plan, the individual doctor will be well into their next year's plan and have lost the benefit of external analysis. Any reflection, either individually or by an accredited provider or "CPD home" needs to occur in a much shorter time frame, such as 2 months to be useful, and again I question whether this administrative burden is worth the effort.
If a plan was to form part of the required professional development it needs to be over a longer time period and be very simple, in the form of an easy to understand template, with clear timelines for both the doctor who completes it and the assessor, in order to provide value to the next plan being developed. An annual plan is onerous, unnecessary and unworkable.
I would recommend discussions with RACGP who tried to introduce a PLAN at the beginning of the last triennium, which was largely rejected by its members, and this was a three-year plan. The RACGP chose to make the PLAN optional after membership feedback.
Should the Board choose to have a professional development plan included in the revalidation process I would recommend it be prescribed more points than is suggested in the document. Most doctors would be unfamiliar with this type of professional development and I believe it would take more than 2 hours to complete, as it needs to be well thought about at inception, reflected upon during the year, and assessed at the end of the reporting period.

Summary

In summary the areas of proposed reaccreditation I am most concerned about are:

1) Annual rather than 3-year accreditation

2) Compulsory assessment of doctors over age 70

3) The 3 categories of CPD being outlined, particularly the "outcome measures" category

4) The potential requirement for multiple "CPD Homes"

5) Lack of detail of how a doctor will know that a "CPD home" has their best interests rather than the interest of sponsors in the provision of professional development

6) The requirement for an annual professional development plan

7) The under allocation of points to the development, reflection and annual assessment of a professional development plan

8) Potential loss of ability to provide self-accredited points

Overall the documents referenced by the EAG seem rather old and thus not necessarily current best practice.

There is no evidence that for the majority of doctors the current system is not largely working well, and that these proposed changes will result in improved capacity of doctors and increased patient safety.

If there is a particular group of doctors that the Medical Board is concerned with then perhaps the review needs to be more targeted.

Please next time you consider providing a document for comment can it be more concise and less repetitive?

It also needs to involve what is missing within the document and what processes are still to be determined, should the recommendations be accepted.

Thank you once again for the opportunity to provide comments.

Yours sincerely,

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