From: Peter French

Sent: Thursday, 13 February 2020 10:01 PM
To: PerformanceFramework
Subject: Consultation on revised CPD Registration standard

Categories: Acknowledged

To whom it may concern,

Re: Consultation on revised CPD registration standard in relation to locum medical practitioners

SUMMARY

The summary of my submission regarding the CPD program is that I believe it may be necessary for the Medical Board and Colleges to include in the program a special category for those older/retired practitioners who continue to remain registered and often provide valuable work and support as locum medical practitioners, especially in regional and remote centres. Whilst being involved in continual **educational activities** may not be difficult, being involved in activities that **review performance** and those that **measure outcomes** may be more difficult than when these practitioners were working full-time. For younger doctors, who are working as locums for a variety of reasons, they still may have the opportunity to be involved in all the activities of a standard CPD program and hence modification to their program may not be necessary.

MY SUBMISSION

With respect, I wish to make a submission, as an individual practitioner, on the proposed CPD Registration standards for 2020 and onwards, in relation to medical practitioners, who for a variety of reasons, undertake **locum work**, especially for those who do so in regional and remote locations.

In making this proposal, I totally support the requirements for all medical practitioners, including those working as locums, to be involved in CPD programs, to demonstrate that they are practising "**competently and ethically and providing safe care to patients**". I would however suggest, that for the older/retired practitioner who is working as a locum, these doctors may not have the same opportunities that they had previously when working full-time (in a hospital/teaching hospital), to satisfy the requirements of the CPD program, especially in relation to the categories of '**reviewing performance**' and '**measuring outcome'** and this needs to be taken into account**.** Perhaps, like other categories that have been proposed, there may need to be a special category created for these locum doctors which would still require them to demonstrate that they are involved in continuing professional development and ongoing learning, in the best interests of their profession and the patients whom they treat.

I believe the majority of people in this group provide a valuable service to the hospitals that they serve, especially in regional and remote centres. However, because they are not working full-time, these doctors may have difficulty in accumulating the necessary CPD points (across the expected three categories) because of the intermittent nature of their employment. However, regardless of their work, all locums should be required to fulfil the principles outlined in the MBA's paper on **Building a Professional Performance Framework** of "**practising competently and ethically and providing safe care to patients"**. I believe that all

practitioners would surely acknowledge that if a locum cannot do this, then they should not be practising at all.

THE LOCUM WORKFORCE

The locum workforce is quite diverse, and is made up of a variety of medical practitioners, who are at various stages in their career, it is not just the "elderly" retired practitioner who works as a locum. In the two years that I have worked as a locum since my retirement from full-time practice in 2017, I have come across young doctors working as locums who are contemplating, or are already enrolled in, formal training schemes, both basic and advanced. They may elect to do locum work to supplement their income, sometimes because of family commitments or because of heavy financial commitments, such as buying a house. Other young doctors may have put a temporary or permanent hold on their training in teaching hospitals and before deciding on the next step in their career, they elect to work as a locum often, but not always, to supplement their income. Others like myself, may be retired medical practitioners who wish to keep working in the profession but not full-time. The doctors that I have come across in the last two years, who are examples of this latter category, are predominantly physicians and anaesthetists. I am not personally aware of any retired surgeons or any other retired specialists (such as psychiatrist) working as locums although of course this would certainly be possible. It is this latter category (the older retired practitioners) who I believe may require some flexibility in their CPD program, **although by no means** should they be exempt from it.

I have read and gone over the papers which were recommended including

1. **BUILDING A PROFESSIONAL PERFORMANCE Framework (MBA)**
2. **DRAFT REVISED REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT (MBA)**

in relation to these changes and as far as I can see, no detailed provision is being made for those retired practitioners, who wish to still continue to work as locums. Locum work is mentioned, in passing on page 5 of the first paper mentioned above, under the section dealing with '**risk from professional isolation'**. At times, locum doctors, who have retired after a clinical career, may find it difficult to obtain the appropriate number of CPD points, with the exception of educational activities, due to the irregular nature of their work, often in multiple locations, often for short periods of time. This may contrast starkly to their previous career, when many may have worked in one institution, such as a teaching hospital, or in one location and would have been involved in many of the activities which are denied to them in their locum work. This would include activities such as consistent involvement hospital wide activities including committee work and also in a wide variety of teaching activities (students, junior staff and registrars in training). However, I believe that like all practising clinicians, locums should be expected to '**maintain contemporary clinical standards and be as well-informed as they can be, compared to their peers who are still working full-time'.** They of course should also be medically fit to undertake the duties for which they have applied and be clinically competent, as judged by their peers and institutions for whom they work. However I also believe based upon my experience, that just like other groups covered in the position paper, a special category may need to be developed for those practitioners who choose to work as locums, as their work may be quite valuable, especially in regional and remote centres, even if they are no longer working full-time, in one location.

MY CIRCUMSTANCE (only as an example)

From 1983 until 2014, I worked in private practice, as a consultant cardiologist, at Calvary Hospital in Canberra.

Throughout this time I was consistently involved in a wide variety of hospital wide activities, including multiple committees, many of which I chaired, teaching of residents and registrars, as well as the nursing staff and also

was involved in the many and varied activities in the Division of Medicine. As well, from 1985 onwards, I was also involved in the activities of the National Heart Foundation of Australia, serving on the local Board, as the President and Vice President and was also involved from time to time in revising guidelines for the National Board. From 2014 until my retirement in 2017, I worked as a staff specialist, the inaugural Director of Cardiology, helping Calvary Hospital to develop a Department of Cardiology and this also involved a considerable amount of committee work and administration of the fledgling Department.

From the early 1990s I was also involved in teaching medical students, initially from the Clinical School affiliated with the University of Sydney and from the early 2000 I was involved with the newly established ANU Medical School (ANUMS), teaching clinical skills and lecturing in cardiology and also selected History of Medicine topics. From 2011 until 2017 I served as the Sub-Dean for ANUMS on the Calvary campus, helping to oversee and coordinate the teaching of students on the Calvary campus and I was also involved in a number of ANU committees associated with this.

Although my training was predominantly in cardiology, and in my private rooms I worked exclusively in cardiology, given that Calvary Hospital was a regional hospital, on the Northside of Canberra, like all of the physicians who are employed by Calvary (sub specialists and general physicians) I worked on the general medical roster as well. This enabled me to maintain some degree of expertise in a number of general medical fields, although I always had the luxury of being able to consult at any time with my colleagues who were trained in other subspecialties such as respiratory, oncology, neurology, rheumatology, and gastroenterology. For many years at Calvary, there were only three physicians who shared many of the on-call and clinical duties but this number has now expanded to over 20. In the early days, working together, the three physicians established many of the programs that are in practice today, such as regular clinical meetings for physicians and hospital wide grand rounds. We also developed and refined the work of many of the hospital committees, on which we served. In the last few years as a staff specialist, I also had quite a lot of administrative and organisational responsibilities. All of these activities legitimately enabled me to claim CPD points across most of the categories.

As the CPD program evolved, given the extent of my clinical duties, as well as committee work and teaching, it was not difficult to satisfy the requirements of this program. Indeed, I am sure that like many practitioners I often omitted to claim credit for the work that I did.

In December 2017, I retired from the hospital and also from the medical school. However as my successful candidate for the new director's position at Calvary was not due to arrive from the UK until May 2018, I worked as a locum back at Calvary Hospital, for one week per month, to cover the cardiology roster. During this time I also was involved in teaching medical students and maintained involvement in some of the committees that I previously been appointed to. This all changed in May 2018.

MY WORK AS A LOCUM PHYSICIAN

Although I had retired, I made the decision that I wished to maintain my registration and also be involved in clinical work and if possible teaching, at the hospitals to which I might be assigned. I also still lecture at the ANU Medical School, albeit for only a few hours, during the cardiological block for year one. Having decided to do locum work, I registered with a locum company and since then have worked in a variety of locations physician, mainly in general medicine but often with a cardiological flavour.

I have undertaken four locum assignments in Tasmania, two in a regional centre (Mersey), one in Launceston Hospital and one in a Private cardiological practice in Launceston. From mid-2019 until the present, I have also carried out many locum assignments at Whyalla Hospital, in South Australia.

Whyalla Hospital could best be described as a small (90 bed) regional hospital, with limited specialist facilities but which receives excellent support from the major teaching hospitals in Adelaide. Junior staff at Whyalla are

secondment from the teaching hospitals (predominately Royal Adelaide) and are often involved in basic training programs, so there is an opportunity to be involved in their teaching, on a daily basis. There is a basic grand rounds program. Students from the University of Adelaide are secondment to the hospital and therefore, at times, there is also the opportunity to teach the students, using the same programs that I previously used at the ANU Medical School. However this does depend on whether I am doing a full week of locum work at Whyalla or merely covering a weekend, which will be the predominant type of work in 2020, as Whyalla now has an extra physician working locally, so the need to have a physician covering for a whole week as a locum is no longer necessary.
Given the circumstances of my locum work covering weekends, the opportunity to be involved in both teaching and hospital activities, which would attract recognition in a CPD program, is made more difficult for me, and for any locum working under these placements. Being involved in educational activities however is not a problem, as I am keen to maintain my knowledge and clinical expertise, and I (attempt) to do this by extensive reading regarding the wide variety of clinical problems the patients under my care have, by reading medical journals that I still receive, and also undertaking online teaching activities, through medical websites that I subscribe to, such as Medscape. Also, when home in Canberra, I still have the opportunity to attend the regular weekly clinical meetings at Calvary Hospital, in 2020.

POTENTIAL PROBLEMS FOR LOCUMS WITH CPD PROGRAMS

Whilst ongoing performance review is desirable, in periods such as when one works **Friday-Monday,** this is almost impossible, as the locum is predominantly covering for a weekend period (Friday night-Monday morning). Although the locum may meet with the hospital staff from whom they are taking over from, during their time of weekend work, the other specialists are generally not present and may have limited or no interaction with the locum except at the time of handover when the locums duties are completed. This would also apply to those doctors who work in the medical administration section of the hospital in which the locum is working.

Therefore, unless there are repeated major problems, observed and reported by other members of staff or that arise on a consistent basis, the locum's work may often be considered acceptable, without any more formal appraisal being undertaken. Outcomes may also be difficult to measure and in reality, the locum is just "**holding the fort**" until normal activity resumes. Involvement in hospital committee work is neither practical nor indeed (probably) desirable, for someone who is not part of the regular hospital set up.

THE OLDER MEDICAL PRACTITIONER

I note in the position paper there are plans to review competence, based upon age-related factors, especially for those practitioners over the age of 70 years. Whilst I have no doubt that some may argue against this(possibly on the basis of age discrimination), I personally think this is not only acceptable, but absolutely necessary. Personally I would have no problem in complying with these requirements. As is repeatedly stated, and reinforced, in the position papers, all doctors should be required to "**practice competently and ethically throughout their working lives and provide safe patient care to patients**". I am sure that all doctors, on reflection, would support this, given the fact that whilst indeed at some point we may be providers of healthcare, all of us are potential patients and at any time could find ourselves on the 'other side of the bed'. Therefore we should all support any measures that maintains patient safety, as it may impact on all of us(positively or negatively), or on members of our family.

SUGGESTIONSFOR CPD PROGRAMS FOR LOCUMS

As mentioned, I totally support the need for locum practitioners to be involved in CPD programs, to demonstrate ongoing commitment to good clinical practice and some degree of improvement, even if late in their careers. I think it would be wise for the Medical Board of Australia to at least investigate, and possibly

include, a special category for locums in the CPD program. This could include but by no means be limited to the following recommendations and points-

1. Locums should be expected to **maintain clinical competence** and to **provide safe and effective evidence-based treatments to patients for whom they care.**
2. Locums should be involved in (? modified) CPD activities.
3. Locums over the age of 70 should be expected to be medically fit and like all of our patients, maintain regular contact with a general practitioner, who may be required to give a independent and hopefully unbiased report on the health and competency of the practitioner.
4. Perhaps an **independent peer/mentor**, from the locum's previous college (e.g. RACP) should be appointed, to liaise with the locum on a regular basis, either by phone/email or direct face-to-face contact, regarding any concerns the locum may have regarding his/her performance and also to liaise with the institution to which the locum has been contracted, as regards any outstanding issues, especially related to clinical performance and competency.

There may indeed be other issues that the Board and the Colleges may suggest and I would leave it in their hands in relation to this matter. I apologise if this submission has been too long-winded in relation to this matter and I thank you for your consideration,

Yours sincerely

Peter French
CARDIOLOGIST

Sent from Mail for Windows 10