General Enquiries and Client Service
P 1800 777 156
F 1800 839 284

Claims and Legal Services
P 1800 839 280
F 1800 839 281

www.miga.com.au
miga@miga.com.au

Postal Address
GPO Box 2048, Adelaide South Australia 5001

18 February 2020

Dr Anne Tonkin
Chair
Medical Board of Australia

Via email – performanceframework@ahpra.gov.au

Dear Dr Tonkin

MIGA Submission – Medical Board proposed new CPD standards

Thank you for the invitation for MIGA to contribute to the Board's consultation on its draft revised *Registration standard: Continuing professional development* (**the draft CPD standard**).

MIGA's Submission to this consultation follows its earlier contributions to the Board's consultations that led to the development of the Professional Performance Framework.[1]

MIGA's position

In response to the draft CPD standard, MIGA's position is that it

- Endorses the need for career-long learning, analysis and reflection in medical practice
- Supports CPD which is relevant and targeted to an individual doctor's career stage, scope of practice, expertise and experience, working context and learning styles
- Considers CPD needs to be balanced appropriately between learning, analysis and reflection, but in ways which are right for individual specialties and doctors, which will vary considerably
- Believes the realities within which doctors work are a crucial part of working out appropriate CPD for particular scopes of practice and individual contexts
- Issues of clinical workloads, role requirements and expectations, fatigue and burnout, and doctors' health must be considered both in assessing CPD requirements, and in working with different craft groups and individual doctors in helping them to complete CPD which is appropriate for them.

It appreciates the considerable work undertaken around the draft CPD standard and Professional Performance Framework more broadly.

MIGA is concerned about the varying impacts that CPD changes will have on different specialties, career stages, practice contexts and working arrangements. These pose significant issues to work through. For example, the impacts will vary considerable between

- Surgeons and GPs
- Pre-vocational junior doctors and specialist trainees
- Full-time and part-time doctors
- Doctors within and outside existing college contexts.

Key issues to consider include specialties where a minimum of 50 hours CPD per annum is not currently a general standard, pre-vocational contexts, reviewing performance and measuring outcomes in non-procedural specialties, responses to non-completion of CPD requirements and transition periods. Refinement and adjustment for these different contexts and issues may be necessary.

[1] See for instance MIGA's Submission to the Board's consultation pre Professional Performance Framework proposals, available here

5. Who does the proposed registration standard apply to?

MIGA supports exclusion of the following groups from the draft CPD standard

- Medical students – their university and clinical training is sufficient, and CPD is not required. Across other professions, CPD is only generally undertaken after completion of tertiary training.
- Interns in accredited intern training programs (see below for more information)
- Doctors granted an exemption or variation by the Board for absence from practice of less than 12 months
- Doctors with non-practicing registration – where they are not practicing, it is not appropriate to require them to undertake CPD. Any need for CPD prior to or on return to practice can be dealt with under the Board's recency of practice registration standard.

It believes there is a good case for exclusion from the final CPD standard of resident medical officers (**RMOs**) who are in their second and third years of medical practice following internship. This is explored below.

6. Interns

6(a) Do you agree that interns should be exempted from undertaking CPD or should they be required to complete and record CPD activities in addition to or as part of their training program?

Yes, interns should be exempted from undertaking CPD.

Their recent completion of tertiary training, and degree of clinical teaching / training through internship, are sufficient. Requiring more would impose an unnecessary load during an already stressful year.

On a similar basis, RMOs within the first three years of practice (i.e. internship through to next two years) should also be exempted from the final CPD standard.

Many of these doctors will transition into specialist training programs in the third or fourth year of medical practice. This would mean they are exempted from the new CPD standard for internship, required to comply with it as an RMO, and then rely on college training programs afterwards. This is unnecessary, could cause significant confusion, and impose an onerous workload in an already pressured and demanding stage of a doctor's career.

MIGA is unconvinced that existing training and education for RMOs in their second and third year following commencement of medical practice is insufficient to meet overall CPD needs.

It would be appropriate to require doctors to meet the new CPD standard if not joining an accredited specialist training program by their fourth year of medical practice.

6(b) If CPD is included as a component of their training program/s, should interns have to comply with the same mix of CPD as other medical practitioners?

No, interns should not have to comply with the same mix of CPD as other doctors.

Although MIGA opposes the CPD registration standard applying to interns, if it was to apply it should be based on recognition of existing activities only.

There is no suggestion that current Australian internships do not provide suitable opportunities for learning, analysis and reflection.

6(c) Should interns have to record what CPD they are doing or is completion of the program requirements sufficient to comply with the standard?

Completion of the internship program would be sufficient to 'comply' with the CPD standard.

Recording completion would be both unnecessary and an undue burden on interns.

7. Specialist trainees

7(a). Do you agree specialist trainees should be required to complete CPD as part of their training program?

MIGA is concerned about a prospect of significant changes to specialist training programs posed by requiring specialist trainees to meet the draft CPD standard.

There is no compelling evidence to suggest completion of an accredited specialist training program does not provide sufficient learning, analysis and reflection for specialist trainees.

To require specialist trainees to complete more is neither necessary nor appropriate.

Whilst the draft CPD standard would recognise specialist training programs as sufficient for meeting its requirements, MIGA is concerned that review of college accreditation standards to ensure that training programs include sufficient activities to meet the new CPD requirements (as foreshadowed in the Board's consultation paper) might have significant, unintended and adverse effects on trainees.

Such changes should be considered only where there is a compelling case for them, tailored to individual specialties and undertaken through wide consultation, particularly with affected trainees.

7(b). If CPD is included as a component of their training program, should specialist trainees have to comply with the same mix of CPD as other medical practitioners?

Although MIGA does not support the CPD registration standard applying to specialist trainees in an accredited college program, if it was to apply the CPD required should be tailored to individual training contexts.

7(c). Should specialist trainees have to record what CPD they are doing or is completion of the program requirements sufficient to comply with the standard?

Any imposition of CPD requirements on specialist trainees (which MIGA does not support), should only be based on completion of training program requirements, without any additional substantive or procedural requirements.

8. International medical graduates

8(a) Should IMGs be required to complete CPD in addition to or as part of their training program or supervised practice?

If an IMG's training program or supervised practice does not contain learning, analysis and reflection which is comparable to appropriate CPD for their scope of practice, or is otherwise insufficient, it is appropriate they be required to undertake CPD comparable to their peers within the same scope of practice.

8(b) If CPD is included as a component of their training program or supervised practice, should IMGs have to comply with the same mix of CPD as other medical practitioners?

Consistent with its views on mix of CPD for different specialties and scopes of practice, MIGA believes the appropriate CPD mix should be based on the specialty or scope of practice in question, but with consideration also given to learning, analysis and reflection equivalent to CPD which an IMG undertakes through specialist training and / or supervised practice.

8(c) Should IMGs have to record what CPD they are doing or is completion of the program requirements or supervised practice plan sufficient to comply with the standard?

Recording CPD should only be for those CPD components which are in addition to that of specialist training and / or supervised practice.

9. Exemptions

9(a) Should exemptions be granted in relation to absence from practice of less than 12 months for parental leave, in addition to serious illness, bereavement or exceptional circumstances?

Yes, exemptions to CPD requirements should be granted for parental leave, in addition to serious illness, bereavement and exceptional circumstances.

9(b) Is 12 months an appropriate threshold?

A period of 12 months exemption from CPD for parental leave is an appropriate starting point or 'default' threshold.

There should be scope for extension in individual circumstances.

The Board's recency of practice standard will also be relevant in circumstances of extended exemptions.

9(c) Should CPD homes grant these exemptions or should the Board?

Given CPD homes will be dealing with a doctors' CPD needs more closely, it is appropriate to provide scope for them to grant these exemptions.

There should be mechanisms for internal review and reconsideration, and Board appeals. This is particularly important in the context of an evolving system that may involve new CPD homes outside college contexts.

10. Practitioners with more than one scope of practice or more than one specialty

10(a) Do you agree with the Board's proposal that medical practitioners with more than one scope of practice or specialty are required to complete CPD for each of their scopes of practice/specialty and where possible this should occur within one CPD home? Do you have alternative suggestions?

It is important that CPD requirements on doctors with more than one scope of practice or specialty do not become unduly onerous.

It would be preferable for this to be co-ordinated by one CPD home, interacting where required with another CPD home.

There should be a focus on cross-accreditation by each CPD home of CPD undertaken by the doctor in another CPD home, wherever possible and appropriate.

11. CPD required

11(a) Are the types and amounts of CPD requirements clear and relevant?

MIGA defers to clinical professional interests, particularly specialist colleges, associations and training bodies, on this issue.

It is concerned that the minimum 50 hours of CPD standard for all doctors will lead to significant changes in types and amount of CPD required of individual doctors.

This is particularly so for the wide range of specialists within college settings where CPD requirements are not presently based on number of hours.

These changes pose particular challenges for doctors who work on a part-time basis.

Often these doctors, due to personal circumstances and commitments, will have considerably less scope to complete a certain amount of CPD than those working full-time.

Consideration should be given to a graduated or differential approach for part-time doctors.

11(b) Should all practitioners, including those in roles that do not include direct patient contact, be required to undertake activities focused on measuring outcomes as well as activities focused on reviewing performance and educational activities?

The right balance of CPD components should be determined through consultation with peak bodies for individual specialties and scopes of practice. Whether this is the 25 / 25 / 25 split between education, reviewing performance and measuring outcomes in all specialties and craft groups, for all career stages and practice contexts, is open to debate.

CPD should focus on individual scope of practice, comparative value of various activities and working contexts.

'Measuring outcomes' will look different across various scopes of practice. Its comparative value may vary.

Many procedural specialties, given their nature and diversity of data available, will find it comparatively easier to measure outcomes than other contexts, such as general practice or a range of physician specialties.

Opportunities to measure outcomes may be considerably greater in a hospital setting as compared with community settings. The hospital processes of M&M meetings, case conferences, multi-disciplinary team meetings and incident reports / root cause analysis mechanisms tend to offer considerably more opportunities for CPD under the draft CPD standard than community settings.

It may be more challenging in particular contexts to review performance. Settings which lack the traditional department structures are not ideal for performance review. Many doctors will need to develop their own structures to permit review, which may be challenging from a practical perspective.

Further consideration should be given to the comparative value of various activities involving review of performance. An hour of peer review may offer considerably more value than a patient experience survey, which may take considerably more hours to put together and analyse. MIGA is concerned that this is not recognised sufficiently, causing undue emphasis on quantity over quality.

Similarly, MIGA is concerned by the diverse range of educational activities that could be given the same value based on hours performed. Activities such as preparing educational materials, teaching, supervising and mentoring, participating in clinical guideline development and writing / reviewing / publishing research or other educational material can each be of considerably more value than participating in / attending educational activities alone. It is concerned that such a differential in value is not recognised sufficiently.

MIGA is concerned to ensure that doctors do not spend undue amounts of time undertaking individual activities involving analysis and reflection, isolating themselves from beneficial interaction with colleagues. The value of activities involving personal interaction for individual well-being and doctors' health should be considered. Interaction at conferences and meetings, in peer review settings and in other one-to-one and group settings can have considerable benefits for health and well-being, and reduce professional isolation. They should be prioritised appropriately.

11(c) If practitioners in roles that do not include direct patient contact are exempted from doing some of the types of CPD, how would the Board and/or CPD homes identify which roles/scopes of practice should be exempt and which activities they would be exempt from?

Exemptions should be considered by the Board and relevant CPD home, in consultation with those doctors practicing within the specialty in question.

12. CPD homes

12(a) Is the requirement for all practitioners to participate in the CPD program of an accredited CPD home clear and workable?

The requirement for affected doctors to participate in the CPD program of an accredited CPD home is appropriate, so long as there is scope for exemption by the Board in individual circumstances, such as scope/s of practice which does not fit within one CPD home, or lack of a CPD home for particular specialty or scope of practice.

12(c) Should the reporting of compliance be made by CPD homes on an annual basis or on another frequency?

Annual reporting of CPD compliance by CPD homes is sufficient. More frequent reporting is unnecessary and may lead to undue resourcing burdens.

12(d) Is six months after the year's end feasible for CPD homes to provide a report to the Board on the compliance of participants with their CPD program(s)?

Subject to confirmation by existing bodies likely to become CPD homes, a six month post CPD year end period for reporting to the Board by the CPD home for CPD compliance appears reasonable. There should be scope for extension in exceptional or other compelling circumstances.

12(e) Should the required minimum number of audits CPD homes must conduct each year be set at five percent or some other percentage?

There should be a transition period of 12 to 18 months after the new CPD standard commences before formal audits. After that period, auditing 5% of doctors for CPD completion seems reasonable, subject to input from those bodies likely to become CPD homes.

12(f) What would be the appropriate action for CPD homes to take if participants failed to meet their program requirements?

No action should be taken if a doctor fails to meet their CPD requirements pending

- Appropriate opportunity to meet those requirements where compliance has been delayed due to unforeseen circumstances
- In other circumstances, completion of a show cause process where the doctor has an appropriate opportunity to be heard on the reasons for non-compliance with program requirements.

These processes, and any consequent Board involvement, should be developed in consultation with key professional stakeholders, including MIGA.

13. High level requirements for CPD programs

13(a) Should the high-level requirements for CPD in each scope of practice be set by the relevant specialist colleges?

Yes, it is appropriate that high-level CPD requirements be set by peak bodies for individual specialties and scopes of practice.

14. Transition arrangements

14(a) What is a reasonable period to enable transition to the new arrangements?

As MIGA identified in its November 2016 contribution to pre-Professional Performance Framework consultations, it is important that moves towards strengthened CPD, as set out in the draft CPD registration standard, be gradual.

This is to ensure the additional time and administrative burdens on doctors are not unreasonable and are spread out. Time must be given to them to get used to a new and different system.

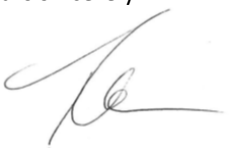
A period of 18 months to two years between new CPD standard finalisation and commencement of new requirements would seem reasonable. There should also be scope for additional time to allow transition for individual specialities and doctors as required.

Next steps

MIGA would welcome the opportunity to engage further with the Board and other key professional stakeholders on these issues.

If you have any questions or would like to discuss, please contact Timothy Bowen, 02 8905 3400 / timothy.bowen@miga.com.au.

Yours sincerely



Timothy Bowen
Senior Solicitor – Advocacy, Claims & Education

Mandy Anderson
CEO & Managing Director