RACGP

Royal Australian College *of* General Practitioners

Submission to the Medical Board of Australia

Draft revised 'Registration standard: Continuing professional development'

February 2020

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The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN: 34 000 223 807

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Medical Board of Australia (the Board) for the opportunity to provide comment on the *Draft revised 'Registration standard: Continuing professional development'*.

The RACGP is Australia's largest general practice organisation, representing more than 40,000 members working in or towards a career as a specialist general practitioner (GP).

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for specialist medical GP training
- maintaining the standards for high-quality general practice care
- supporting specialist GPs in their pursuit of excellence in patient and community service.

2. RACGP position

The RACGP's response builds on feedback provided in its previous submission (October 2019), and has been informed by:

- extensive consultation with members
- an analysis of the likely impact of the proposed changes
- the recent changes made by the RACGP to its Continuing Professional Development (CPD) Program for the 2020–22 triennium, and how these relate to the changes proposed by the Board's Professional Performance Framework.

The RACGP supports:

- the continuation of the current CPD standards that incorporate continuous improvement
- the requirement for all medical practitioners, including non–vocationally registered practitioners, to identify their CPD home
- CPD homes being set only by medical specialist colleges
- CPD requirements for each unique scope of practice being determined only by the single relevant specialist medical college.

The RACGP does not support:

- allowing new providers to establish alternatives to medical specialist CPD homes outside medical specialist colleges
- allowing medical practitioners to transition between CPD homes with identical scope of practice
- the potential requirement for practitioners with multiple specialties/operating across multiple practice scopes to complete separate CPD programs for each specialty/practice scope
- replacing the current points system with mandated hours
- the requirement for annual reporting.

3. Rationale

3.1 The role of specialist medical colleges in CPD

3.1.1 All medical practitioners should have a CPD home

The RACGP supports the proposal to require all medical practitioners, including those non–vocationally registered, to identify and join an accredited CPD home relevant to their specialty or scope of practice.

A proposed change to the standard (p. 13 of the draft document) is to specify 'CPD homes recommended for each category of registrants'. The Board should clarify whether this means the specialist medical colleges will be the required CPD homes for each relevant specialist category. Refer to the question 12 response.

3.1.2 New CPD providers for unique scope of practice are not needed

The Board proposes to allow for the introduction of new providers who can establish alternative accredited CPD homes. The RACGP strongly opposes allowing new providers to establish alternatives to medical specialist CPD homes outside medical specialist colleges.

3.1.3 The CPD home must be within the relevant specialist medical college

The RACGP considers that the CPD home should be where the medical practitioner's specialist qualification/s were obtained – that is, the specialist medical college. For medical practitioners who are non–vocationally registered, identification of their scope of practice would indicate their most appropriate CPD home/s.

Broadening practitioners' choices as consumers is commendable, but this may have an unintended consequence of weakening the overall integrity of a high-functioning CPD program. There is a risk of creating a two-tier system if CPD programs are created outside the specialist medical college environment for identical scope of practice by new providers, particularly if their primary business offering is not medical education. For medical practitioners to fully understand the possible implications of the proposal, the Board should provide further advice on which types of organisations might become CPD homes and how Australian Medical Council (AMC) accreditation would be achieved.

Allowing practitioners to change CPD homes with the same scope of practice, and consequently involving multiple regulatory agencies, will weaken CPD program compliance in direct opposition to the goal of continuous improvement through CPD. Allowing practitioners to move between CPD homes will weaken the ability of a CPD home to monitor a practitioner's adherence to requirements. It will also weaken the ability of practitioners to plan, track and reflect on their CPD over time.

The RACGP contends that no medial practitioner should be outside the jurisdiction of the relevant specialist medical college. Registration as a practising medical specialist should be contingent upon membership and active participation within the relevant specialist medical college's CPD program. Failure to do so dilutes the quality and safety of patient care, potentially placing the community at risk.

Specialist medical colleges play a crucial role ensuring in strengthening CPD programs as well as in determining performance benchmarks, supporting program participants, managing records and reporting. It is strongly recommended that CPD requirements are developed by the relevant specialist medical college, thereby ensuring they are aligned with the unique circumstances of each profession. Specialist medical colleges are the only bodies with the expertise to do this; however, if the significant changes proposed come into effect, their capacity to do this may be hampered.

3.2 Major impact of CPD changes

3.2.1 Introduction of changes will significantly impact on GP workforce capacity

The RACGP disagrees that the proposed changes will have only minor impact on the organisations that currently manage CPD programs (ie specialist medical colleges).

Members expressed concern that the proposed changes would place more pressure on GPs, escalate already poor levels of morale, increase stress, and contribute to higher rates of attrition within the GP workforce.

As GPs practise across a wide and diverse range of environments, there was significant concern that the proposed changes would introduce inequity, and disadvantage those working part time or as professional locums and rural GPs. Such GPs work with vulnerable populations, might have limited or unreliable access to full patient records, or must deal with a lack of continuity of care. Their ability to participate in activities that access performance or measure outcomes can be limited.

Respondents to the RACGP's survey raised concerns that the proposal was unsuitable for the unique environment and conditions of general practice:

> *'Already, when undertaking CPD, most GPs do so in their own time and at their own expense. Our hospital colleagues have paid professional development leave in their award, as well as a budget for undertaking CPD itself. Any CPD done by the average GP involves unpaid time, as well as a cost of the CPD.'*

> *'GPs are already under strain in a system that is under-resourced. We spend many unpaid hours caring for patients, which we do willingly; however, this puts such a significant burden on our precious time. This in a [GP] population where self-care is already not prioritised or easy to fit in. Of course CPD must be upheld to a certain standard but please be reasonable and contextual.'*

> *'This is a further disincentive for people to become [a] GP; the proposed changes may suit hospital-based doctors who are salaried and can have their teams do patient surveys etc, but is not feasible for small businesses of general practice.'*

The RACGP questions the need for such wide-ranging and disruptive changes in a CPD system that is fit for purpose, constantly self-improving, and producing good outcomes (as evidenced by the very low rate of complaints resulting in punitive action). Rather, the proposal is perceived by members as less flexible than the current system, and creating an unnecessary administrative burden of compliance.

The lack of a case for change was a strong theme from the RACGP's survey, with free-text responses such as:

> *'Why undertake major changes to a system when there is no clear evidence that any proposed change will significantly influence patient outcomes?'*

> *'I am not convinced there is evidence to support a major disruption to college-led CPD programs.'*

> *'All I see at the moment is activities with LESS clinical and LESS educational relevance and a MUCH higher burden of compliance.'*

> *'The need for such disruption is questioned, particularly in the face of no evidence that the current system is failing.'*

Feedback from RACGP members consistently highlighted that CPD requirements must consider the unique circumstances of general practice, and not rely on educational literature alone.

3.2.2 Practical implementation presents a major barrier for the general practice environment

Members expressed concern that the proposed changes would place more pressure on GPs, escalate already poor levels of morale, increase stress, and contribute to higher rates of attrition from the GP workforce.

As GPs practise across a wide and diverse range of environments, there was significant concern that the proposed changes would introduce inequity, and disadvantage those working part time or as professional locums

and rural GPs. Such GPs work with vulnerable populations, might have limited or unreliable access to full patient records, or must deal with a lack of continuity of care. Their ability to participate in activities that access performance or measure outcomes can be limited, resulting in practical barriers to meeting the proposed CPD requirements.

Compared to other medical specialists who work in salaried hospital environments where access to CPD activities is incorporated into their working day, GPs are significantly disadvantaged. The introduction of revised standards for CPD will exacerbate these problems.

Respondents to the RACGP's survey raised concerns that the proposal was unsuitable for the unique environment and conditions of general practice:

> *'Already, when undertaking CPD, most GPs do so in their own time and at their own expense. Our hospital colleagues have paid professional development leave in their award, as well as a budget for undertaking CPD itself. Any CPD done by the average GP involves unpaid time, as well as a cost of the CPD.'*

> *'GPs are already under strain in a system that is under-resourced. We spend many unpaid hours caring for patients, which we do willingly; however, this puts such a significant burden on our precious time. This in a [GP] population where self-care is already not prioritised or easy to fit in. Of course CPD must be upheld to a certain standard but please be reasonable and contextual.'*

> *'This is a further disincentive for people to become [a] GP; the proposed changes may suit hospital-based doctors who are salaried and can have their teams do patient surveys etc, but is not feasible for small businesses of general practice.'*

3.3 Measuring and ensuring compliance

The Board proposes to introduce annual reporting of CPD compliance, and require 50 hours per year across three types of CPD activities.

3.3.1 Hours versus points

The RACGP sees no evidence to support a change from a qualitative points system to the accumulation of quantitative educational activity 'hours'.

It is noted that 75% of specialist medical colleges currently use points rather than hours, which allows for a qualitative value to be attached to activities of higher educational value. This is an example of strengthening CPD through a 'smarter not harder' approach, which the various specialist medical colleges continue to refine as needed.

RACGP members report that the current points system is preferable to counting hours, as points are seen as the best way to measure the quality of the educational activity. Frequently, GPs stated that the nature of their practice inherently incorporated continuous learning and development, and the need to record 50 hours of CPD will create a 'tick box' mentality and increase administrative paperwork, wasting time and effort.

Many survey respondents raised similar concerns:

> *'CPD must be relevant to the doctor and his/her practice. The quality of CPD and relevance are far more important than quantity. This is the old problem of measurement – quantity is always easier than quality.'*

> *'Time is not a measurement of success in CPD.'*

3.3.2 Reporting cycles

The RACGP CPD Program cycle is three years, and a new triennium commenced in January 2020. The current program cohort is more than 30,000 medical practitioners. The RACGP sees no need for (or evidence to support) changing to an annual reporting period. This would be a significant disruption to current arrangements for RACGP members, with no apparent benefit realised.

RACGP members have provided feedback that supports maintaining the triennial reporting period, as this creates more flexibility to meet requirements. A longer reporting period is particularly relevant to general practice, which is unique in its continuity of care element; many patient outcomes are best measured over a period longer than one year.

Survey responses on this topic included:

> *'Part-time GPs often have to juggle triennium CPD around having babies, starting school year etc, and being able to concentrate and get CPD done in a short time for the three years has been invaluable.'*

> *'General practice is unique in its continuity of care. Many of the outcomes we are interested in cannot be measured within one year.'*

3.3.3 Ensuring compliance

CPD cycles vary between specialist medical colleges from one to three years. As compliance can only be determined at the end of the cycle, compliance reporting should be consistent with the length of the CPD cycle – that is, yearly, biannually or each triennium.

The RACGP believes that a three-month period of reporting compliance after the end of the relevant CPD cycle provides ample time to fulfil any CPD remediation requirements.

The RACGP maintains a high level of compliance through proactive and ongoing monitoring throughout the triennium. The proposal to introduce additional CPD homes poses a risk to increased levels of non-compliance if similar attention is not provided or is restricted by operational or commercial considerations.

4. Data and privacy issues

The Board proposes to work with other agencies to urge holders of 'large data' to make data accessible to individual registered medical practitioners. The rationale for this proposal is to 'improve safety and quality', presumably by enabling greater self-reflection and measurement of outcomes of care provided, including benchmarking against peers.

The RACGP seeks further information regarding this proposal, and what it looks like in practice. There are wide-ranging privacy and process implications that must first be considered.

The RACGP requests additional information on this proposal before it can comment on the use of external data sources in the context of improving patient care.

5. Transition period and further consultation

The Board has significantly underestimated the potential impact of many elements of the proposal, and the concerns GPs have about the proposal. Therefore, it is strongly recommended that the Board undertake further consultations with the medical profession prior to finalising the CPD registration standard.

Additionally, a significant transition period is required if/when details of implementing the new standard are determined. At a minimum, the transition should include consideration of current CPD cycles (eg until the end of the current CPD triennium for general practice in 2022).

Responses to Draft revised 'Registration standard: Continuing professional development'

1. Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?

RACGP response: The content and structure of the draft is clearer than the previous standard. Please note and consider the suggested revisions in this submission.

2. Is there any content that needs to be changed or deleted in the draft revised standard?

RACGP response: Overall, the wording of the standard is clear, but the RACGP has the following suggestions.

a) In the section stating:

- *allocate your minimum 50 hours per year proportionately among three types of CPD activities:*
  - *at least 25 per cent in educational activities*
  - *at least 25 per cent in activities focussed on reviewing performance*
  - *at least 25 per cent in activities focussed on measuring outcomes, and*
  - *the remaining 25 per cent (and any CPD activities above the 50-hour minimum) across any of these types of CPD activity.*

  NOTE: CPD homes can allocate points to CPD activities if the points can be translated to hours.

There is some ambiguity in this statement regarding the use of the word 'minimum' and the application of the percentages. The RACGP suggests the use of minimum number of hours per year instead, and clarifying the impact for medical practitioners who do more than 50 hours minimum per year. The RACGP recognises that the section stating '(and any CPD activities above the 50-hour minimum)' implies this, but the RACGP feels that this is not explicit enough.

If a medical practitioner completes, for example, 150 hours of CPD during the year, are these percentages applied across the practitioner's entire 150 hours?

Requiring a percentage rather than a number of hours is a disincentive for medical practitioners to attend educational activities if this means that they will then have to achieve the percentages in the other categories (ie performance review and outcomes measurement), which could prove difficult.

Moreover, if percentages are applied, medical practitioners who participate in higher levels of CPD activities might then not meet the CPD registration standard, which contradicts the aims of the standard.

The suggested changes could be as follows (underlined):

- *allocate your minimum 50 hours per year proportionately among three types of CPD activities:*
  - *at least 25 per cent in educational activities (minimum 12.5 hours per year)*
  - *at least 25 per cent in activities focussed on reviewing performance (minimum 12.5 hours per year)*
  - *at least 25 per cent in activities focussed on measuring outcomes (minimum 12.5 hours per year), and*

- *the remaining 25 per cent (minimum 12.5 hours per year and any CPD activities above the 50-hour minimum) across any of these types of CPD activity.*

NOTE: CPD homes can allocate points to CPD activities if the points can be translated to hours.

This would then be consistent with the way in which the CPD examples are listed on page 26 of the draft document.

b) This is not a comment about the registration standards, but about the draft document section 'What CPD is required' and the proposed lists as guidance.

Although the information about what CPD is required is not a part of the CPD registration standard, there will need to be some standards as to what constitutes appropriate and required CPD for interpretation, especially during audits.

While the RACGP recognises that the lists in the tables 'Educational activities' (p. 27), 'Reviewing performance' (p. 28) and 'Measuring outcomes' (p. 28) are provided as examples to illustrate the types of activities, there needs to be emphasis that these are examples only and not the only recognised learning activities or an expected standard. If there is an expected standard, this needs to be explicitly incorporated within the CPD registration standards.

There are learning activities that have demonstrated efficacy in changing clinician behaviour that are not listed in these tables – for example:

- undertaking point-of-care and patient-oriented activities, and problem-based learning through instructional technologies[1]
- participating in learning communities[2]
- learning collaboratively through the use of social media, which has been shown to change peer behaviour.[3,4]

New, designated types of evidence-based learning activities – such as found in specialist medical colleges and CPD homes – provide a platform for educational innovation. Restricting educational lists to those proposed as guidance has the potential to reduce educational innovation.

Currently, educational activities are assessed and validated through an accreditation process, and the RACGP holds the view that this is the domain of educational accreditation authorities.

3. Is there anything missing that needs to be added to the draft revised standard?

Refer to the question 2 response.

4. Do you have any other comments on the draft revised CPD registration standard?

Refer to the question 2 response.

The Board is also interested in your views on the following specific questions.

5. Who does the proposed registration standard apply to?

a) Should the CPD registration standard apply to all practitioners except the following groups?

- medical students
- interns in accredited intern training programs
- medical practitioners who have limited registration in the public interest or limited registration for teaching or research (to demonstrate a procedure or participate in a workshop) and who have been granted registration for no more than four weeks

- medical practitioners who are granted an exemption or variation from this standard by the Board in relation to absence from practice of less than 12 months
- medical practitioners with non-practising registration.

RACGP response: The RACGP is in agreement with this view.

b) Are there any other groups that should be exempt from the registration standard?

RACGP response: The RACGP believes there are no other groups of medical practitioners requiring exemption.

6. Interns

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?

RACGP response: The intern and junior doctor training program is currently a dynamically evolving area in Australia, and making decisions at this point of time when training programs might be undergoing significant change may be premature. If change is implemented and additional requirements introduced, the intern year might extend to two years, which could cause difficulties with CPD compliance during transition. There might also be changes in how interns move to specialist training programs, which may further complicate CPD transitional arrangements.

Interns receive considerable supervision and performance feedback, and participate in CPD. Compared to qualified specialist medical practitioners, they receive a higher degree of monitoring for patient safety, as is appropriate for their level of training. Many specialist medical training programs require documentation of clinical experience and educational activities as part of their training program entry requirements, so recording CPD is good professional practice and is to be encouraged. However, if the intern training program curriculum and learning program is monitored by the AMC, recording of CPD may contribute little to patient safety.

As an interim position until the structure of intern training is finalised, interns should be strongly encouraged to record all CPD, including supervision, to foster good professional practice. Electronic point-of-care tools for this are currently available and are being developed for use by various specialist medical colleges.

When the changes to intern training programs are finalised, reconsider making CPD recording compulsory.

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?

RACGP response: Levels of supervision need to be matched to the experience of the clinician to ensure patient safety. Interns have high levels of supervision, so increasing the percentage of performance feedback is unlikely to be a difficult target to reach. Even if the target is reached, most interns would receive greater amounts of feedback than the required minimum.

A better standard might be for training programs, using with the appropriate evidence base, to document the proportion and mix of CPD activities appropriate for the stage of supervision. This could be reviewed during AMC accreditation.

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

RACGP response: Refer to the question 3 response. Interns are encouraged to document CPD, but meeting the overall AMC accredited training program requirements should be sufficient to comply with the CPD registration standard. This is because the level of supervision and performance feedback is likely to be much higher than for a qualified medical specialist, as is appropriate for their level of training.

7. Specialist trainees

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

RACGP response: As discussed in the response to question 6, specialist medical trainees receive considerable supervision and performance feedback, and participate in CPD.

Many specialist medical training programs require documentation of clinical experience and educational activities as part of their training program entry requirements, so recording CPD is good professional practice and is to be encouraged. Most specialist colleges provide tools for this.

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?

RACGP response: A better standard might be for training programs, using with the appropriate evidence base, to document the proportion and mix of CPD activities appropriate for the stage of supervision. This would be reviewed during AMC accreditation. The RACGP currently applies this standard in its *Standards for general practice training*, where minimum teaching and supervision times are documented.

As the level of supervision required varies considerably for each individual trainee, the CPD activity mix would need to be flexible to meet individual trainee learning needs. This is best done within the context an AMC-accredited, structured training program rather than a CPD standard.

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?

RACGP response: Recording of CPD is good professional practice and should be encouraged for all medical practitioners. However, meeting specialist training program requirements would be a more suitable measure of assuring patient safety.

8. International medical graduates [IMGs]

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

RACGP response: Yes.

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?

RACGP response: As discussed above, as the required supervision varies considerably for each individual trainee, the CPD activity mix would need to be flexible to meet individual trainee learning needs. This is best done within the context of an AMC-accredited, structured training program rather than a CPD standard.

If the IMG is not in an accredited program, they should meet the same CPD standard.

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?

RACGP response: If an IMG is in an accredited training program, the same principle to that highlighted in the response to question 8b applies.

9. Exemptions

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?

RACGP response: This is appropriate.

b) Is 12 months an appropriate threshold?

RACGP response: This is appropriate.

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

RACGP response: CPD homes can do this. As CPD homes will be accredited by the AMC, this can be included in accreditation standards. The Board will be able to monitor this through re-registration.

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

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?

RACGP response: Yes, the Board's proposal is in the best interests of patient safety, but only if the scope of practice-related CPD cannot be met by a single specialist medical college and has CPD requirements from two specialist medical colleges. An example would be a medical practitioner holding a specialist qualification from two medical specialist colleges. Otherwise, as far as possible, the medical practitioner should limit their CPD home to one specialist medical college covering their scope of practice.

11. CPD required

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

RACGP response: Refer to question 2b response.

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

RACGP response: Yes.

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?

RACGP response: Refer to the question 11b response.

12. CPD homes

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

RACGP response: A medical practitioner registered as a specialist should undertake their CPD at a relevant medical specialist college, as these have experts in standard setting for CPD for a given specialty.

The RACGP supports the proposal to require all medical practitioners, including those non–vocationally registered, to identify and join an accredited CPD home relevant to their specialty or scope of practice.

b) Are the principles for CPD homes helpful, clear, relevant and workable?

RACGP response: Specialist medical colleges need to be the sole CPD standard setters for a particular scope of practice.

Specialist medical colleges play a crucial role in strengthening CPD programs, as well as in determining performance benchmarks, supporting program participants, records management and reporting. To ensure alignment with the unique circumstances of each profession, it is strongly recommended that CPD requirements are developed by the relevant specialist medical college. Specialist medical colleges are the only bodies with the necessary expertise. If the significant changes proposed come into effect, their capacity to perform this vital role may be hampered.

A proposed change to the standard (p. 13 of the draft document) is to specify 'CPD homes recommended for each category of registrants'. The Board should clarify whether this means the specialist medical colleges will be the required CPD home for the relevant specialist category.

The RACGP reinforces that if the scope of practice of a medical practitioner lies within the remit of a particular specialist medical college, then that medical practitioner **must** be a member of that specialist college's CPD program to ensure compliance with that specialty's performance standards can be ensured.

There must be only one relevant CPD program for each scope of practice. This way medical practitioners cannot change CPD homes to avoid regulatory CPD compliance requirements for their scope of practice.

A medical practitioner whose scope of practice lies within the remit of a specialist college must not be able to complete that specialty's relevant CPD at a different CPD home other than that of the relevant specialist medical college.

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

RACGP response: The compliance period should match the CPD period as designated by the medical specialist college. If the college has a three-year period, compliance should be three-yearly.

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)?

RACGP response: This is an appropriate time period to allow CPD participants to meet any CPD remediation requirements.

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

RACGP response: This is a generally accepted educational institution standard and the RACGP believes that this is acceptable.

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

RACGP response: Candidates who fail to meet their CPD requirements should be referred to the CPD home's remediation processes. In addition, CPD homes should be required to have measures in place for early detection of CPD program participants who appear to be failing to meet their requirements.

In the case of the RACGP, we would have the participant undertake a skill assessment against the RACGP curriculum, then institute a remedial program so that they can meet the CPD standards. This would need to be performed in conjunction with the Board.

13. High-level requirements for CPD programs

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

RACGP response: Yes. They are the experts and will be aware of changing requirements. In addition, being educational innovators, they will be aware of evolving educational methodologies to improve the quality of CPD for their particular medical specialty.

14. Transition arrangements

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

RACGP response: This will vary depending upon the level of training. A three- to five-year period would allow for current CPD cycles of most medical specialist colleges.

For interns and junior doctors, as this area is in transition, some flexibility may be required to ensure that CPD requirements are appropriate for the relevant level of training.

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