Context and summary of available evidence for changes to CPD.

Purpose of this document

This document summarises core evidence provided by the Regulators and outlines the key College commitments that underpin changes to the RACP MyCPD framework for 2023. This document does not attempt to cover the full evidence base and should be read in conjunction with the more comprehensive documents provided by the regulators (see section 2).

1. Changes to CPD.

Regulatory changes to CPD are outlined in the relevant standards.

- Medical Board of Australia (MBA). Registration standard: Continuing professional development. Effective from 1 January 2023. Released 30 July 2021.
- Medical Council of New Zealand (MCNZ). Recertification requirements for vocationally registered doctors in New Zealand. Releases November 2019.

2. Evidence provided by the Regulators

The evidence provided by the MBA for its changes is in the final report of its expert advisory group[1] (pages 34 – 45). The evidence base for the changes by the MCNZ is in its literature review to support strengthening of recertification.[2]

The Regulators' documents look at the general effectiveness of a range of CPD activities as well as referencing evidence for the effectiveness of specific activities like multisource feedback[3].

2.1. Mandatory requirement for activities that review performance (category 2) and measure outcomes (category 3).

The College has always recognised the educational value and impact of activities that review performance and measure outcomes by giving them higher credits per hour in its previous CPD frameworks. While those frameworks did not mandate the activities, they did recognise their effectiveness in creating change.

The MBA, in outlining the evidence for change, points to Bloom's investigation of the effects of continuing education on physician clinical care and healthcare outcomes[4]. The MBA summarises the findings as follows:

> *The most valuable methods were interactive, including audit of patient data with feedback on results, academic detailing, interactive educational events, and reminders, all of which demonstrated an impact on performance improvement and improved patient outcomes. A moderate effect was found for clinical practice guidelines and*

[1] Medical Board of Australia. Final report of the expert advisory group on revalidation. August 2017
[2] Medical Council of New Zealand. Literature review. Recertification. Evidence to support change. July 2017
[3] 'ibid' MBA pg 39 MCNZ pg 3
[4] B.S. Bloom, 'Effects of continuing medical education on improving physician clinical care and patient health: a review of systematic reviews', *International Journal of Technology Assessment in Health Care*, vol. 21, no. 3, 2005, pp. 380-5.

opinion leaders. However, didactic presentations and printed materials alone were shown to have little or no beneficial effect on either performance or outcomes. [5]

The MCNZ includes Bloom's examination of the impact of a range of delivery modalities separating how those modalities impact on physician behaviour and on patient outcomes. [6]

(Reading these tables: The column on the right gives the number of papers reviewed and then the % figure in each column is the % of those papers identifying that level of impact. For example: in table 2: there are 23 papers examining 'Audit with feedback …'. Of those papers 26% found a high impact of audit, 48 % a moderate impact etc)

Table 2. Effect on care delivered, % of papers	***High***	***Moderate***	***Low***	***None***	***Number of papers***
Academic detailing (face-to-face education by pharmacists etc)	*100%*				*6*
Reminders	*35%*	*46%*	*19%*		*26*
Interactive education	*29%*	*35%*	*24%*	*12%*	*17*
Audit with feedback on difference between actual and optimal performance	*26%*	*48%*	*17%*	*9%*	*23*
Didactic programs		*15%*	*35%*	*50%*	*20*
Opinion leaders		*33%*	*45%*	*22%*	*9*
Guidelines		*60%*	*40%*		*5*
Information only		*15%*	*23%*	*62%*	*13*

Table 3. Effect on health outcomes, numbers of papers, % of papers	***High***	***Moderate***	***Low***	***None***	***Number***
Didactic programs				*100%*	*4*
Interactive education		*43%*	*16%*	*43%*	*7*
Audit with feedback on difference between actual and optimal performance		*50%*	*30%*	*20%*	*10*
Academic detailing (face-to-face education by pharmacists etc)	*17%*	*66%*	*17%*		*6*
Opinion leaders	*100%*				*1*
Reminders	*22%*	*44%*	*22%*	*11%*	*9*
Guidelines		*100%*			*1*
Information only			*33%*	*66%*	*3*

The MCNZ concludes:

By ranking the data, the most effective delivery methods are academic detailing, reminders and interactive education. Audit with feedback has moderate effects. Didactic programs, guidelines, opinion leaders and isolated information have little effect.[7]

[5] MBA Final report of the expert advisory group on revalidation. August 2017 pg. 35.
[6] Medical Council of New Zealand. Literature review. Recertification. Evidence to support change. July 2017. Pg 3
[7] MCNZ. Literature review. Recertification. Evidence to support change. July 2017 Pg 3.

Both regulators point to Cervero and Gaines[8] synthesis of eight systematic reviews of the literature about the effectiveness of CPD (referred to in their paper as CME), published since a 2003 review. The MBA states:

> *'Cervero and Gaines concluded that CPD:*
>
> - *is able to improve clinician performance and patient health outcomes*
> - *has been shown to be more reliably positive in its impact on clinicians' performance than it has been on patient health outcomes. The effect of CPD on patient outcomes has been more difficult to demonstrate due to the complexity of intervening variables, and*
> - *leads to greater improvement in physician performance and patient outcomes if it is interactive, uses more methods, involves multiple exposures, is longer, and is focused on outcomes that are considered important by clinicians.*
>
> *In summary, Cervero and Gaines concluded that exposure to multiple modalities and multiple events will increase the likelihood of a change in performance and subsequent change in patient health outcomes. Their findings infer that educational interventions that are based on the concept of a performance improvement process involving feedback from ongoing, multimodal, interactive education and performance assessment, delivered sequentially, is more important than single or isolated educational events.*
>
> *These systematic reviews demonstrate that the ability of CPD to create changes in performance or health outcomes is critically dependent on how it is designed and presented to learners.'* [9]

Both Regulators acknowledge this last point that the design and delivery of activities is crucial to their success and outline the factors that support that success. The MBA lists the guiding principles for change, ie. that high quality CPD programs:

- *are evidence-based*
- *are based on a professional development plan*
- *are interactive, use multiple methods and involve multiple exposures*
- *focus on outcomes that individual doctors wish to attain and which support their individual practice*
- *aim to improve doctors' performance and behaviours and their patient outcomes*
- *emphasise the role of self-reflection*
- *provide credible and practical feedback*
- *are integrated with existing systems to avoid duplication of effort*
- *are led by the profession, and*
- *encourage collaboration within the profession.*[10]

The College is attempting to organise access to the full versions of the articles by Cervero and Gaines and Bloom. If you would like to review those articles, please email a request to mycpd@racp.edu.au.

[8] R.M. Cervero and J.K. Gaines, 'The impact of CME on position performance and patient healthcare outcomes: an updated synthesis of systematic reviews', *Journal of continuing education in the health professions*, vol. 35, no. 2, 2015, pp. 131-138.
[9] MBA Final report of the expert advisory group on revalidation. August 2017 pg. 35.
[10] 'ibid' pg 44.

2.2. Mandatory requirement for a Professional Development Plan and for an Annual Conversation.

The MBA reviewed the literature on the effectiveness of self-assessment in planning CPD activities and drew the following conclusions about the importance of external assessment in the identification of professional development needs:

> *Self-assessment is critical to this process but a literature review has shown that, while suboptimal in quality, the preponderance of evidence suggests that physicians have a limited ability to self-assess accurately*[11]*.… the processes currently used to undertake professional development and evaluate competence need to focus more on the results of external assessment. Examples include feedback from peer review, evaluation of outcomes based activities and high quality data based on standards.* [12]

The MBA concludes:

> *A written professional development plan (PDP) helps ensure that medical practitioners reflect on the value and appropriateness of proposed CPD activities before and after undertaking them. The PDP process for CPD is conceptualised as informed self-assessment taking into account all factors that may influence doctors' fitness to practise.*[13]

The annual conversation similarly seeks to provide an element of external assessment to assist in this process of review, reflection and self-assessment and is described by the MCNZ as follows.

> *… The intent of this activity is to provide time for the doctor to reflect on their development needs, their goals for learning and professional activities and their intentions for the next year. Doctors are encouraged to use the information they have obtained undertaking activities across the three types of CPD to inform this conversation.*
>
> *It provides an opportunity to receive constructive feedback and share best practice. It may also give doctors the opportunity to explore their satisfaction in their current role, self-care and any health and wellbeing issues so they are able to adjust their practice accordingly, set performance targets for the future, and consider longer-term career aspirations.*[14]

[11] D.A. Davis, P.E. Mazmanian, M. Fordis, R. van Harrison, K.E. Thorpe and l. Perrier, 'Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence; A Systematic Review', *JAMA*, vol. 296, no. 9, 2006, pp. 1094-1102.

[12] MBA Final report of the expert advisory group on revalidation. August 2017 pg. 36.

[13] 'ibid' pg 36

[14] Medical Council of New Zealand (MCNZ). Recertification requirements for vocationally registered doctors in New Zealand. November 2019. Pg 8.

3. Completion of CPD with a focus on Cultural Safety and Health Equity is strongly encouraged.

The MCNZ mandates that cultural safety and issues of health equity are embedded in all CPD activities from 2023. AHPRA, the MBA and the Australian Medical Council set explicit requirements for the accreditation of CPD providers (such as the RACP) to facilitate the practice of culturally safe healthcare for Aboriginal & Torres Strait Islander peoples ie. both regulators have a focus on individual practitioner roles in the facilitation of culturally safe healthcare.

Cultural safety is relevant to all minority cultures and groups within a society and CPD that has a focus on providing culturally safe care for any minority culture or group, or that has focus on redressing health inequities for those groups, will meet this requirement.

The MCNZ when defining cultural safety[15] draws on work done by Curtis et al.

> *"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.".*[16]

Laverty et al. in reviewing available literature, while acknowledging that there is not a wide evidence base, call for the embedding of cultural safety in professional standards.

> *Cultural safety requires embedding in not only course accreditation for each health profession — including measures to reduce resistance — but also in the standards governing clinical professionalism and quality, such as the Royal Australian College of General Practitioner Standards for general practices, and the Australian Commission on Safety and Quality in Health Care National safety and quality health service standards.*[17]

The College Education Committee has recently approved a new 'Professional Standard for Cultural Safety'. This standard outlines the behaviours that characterise Physician behaviour in delivering culturally safe care and this mandatory CPD requirement is designed to support the development of the skills, attitudes and behaviours required to meet this standard:

> ***Physicians engage in iterative and critical self-reflection of their own cultural identity, power, biases, prejudices and practising behaviours.*** *Together with the requirement of understanding the cultural rights of the community they serve; this brings awareness and accountability for the impact of the physician's own culture on decision-making and healthcare delivery. It also allows for an adaptive practice where power is shared between patients, family, whānau and/or community and the physician, to improve health outcomes.*
>
> ***Physicians recognise the patient and population's rights for culturally safe care, including being an ally for patient, family, whānau and/or community autonomy and agency over their decision-making.*** *This shift in the physician's perspective fosters collaborative and engaged therapeutic relationships, allows for strength-based (or mana-enhanced) decisions, and sharing of power with the recipient of the care; optimising health care outcomes.*
>
> ***Physicians critically analyse their environment to understand how colonialism, systemic racism, social determinants of health and other sources of inequity have and continue to underpin the healthcare context.*** *Consequently, physicians then can recognise their*

[15] Medical Council of New Zealand. Statement on cultural safety. October 2019. Pg 2
[16] Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. International Journal for Equity in Health,
[17] Laverty R, McDermott D R, Calma T. Embedding cultural safety in Australia's main health care standards. Medical Journal of Australia. 207(1):15-16. July 2017

> *interfacing with, and contribution to, the environment in which they work to advocate for safe, more equitable and decolonised services and create an inclusive and safe workplace for all colleagues and team members of all cultural background.*[18]

This strong encouragement for Fellows to complete CPD that focusses on cultural safety and health equity is to support the commitments made and priorities set by the College through its Indigenous Strategic Framework and the RACP Statement on Indigenous child health in Australia and New Zealand and is an initial step towards embedding cultural safety and health equity in all CPD activities.

The RACP Statement on Indigenous child health identifies one of RACP's priorities in this area as the need to *'Prioritise Indigenous health in its training, assessment, supervision, mentoring, continuing professional development requirements and education activities.'*[19] It recommends:

> *The Continuing Professional Development programme (MyCPD) requirements are a means by which the RACP signals its priorities and sets its expectations of Fellows. The MyCPD points credit system should reflect the high value the College places on cultural safety and Indigenous Health training and the expectation that Paediatricians continually develop their understanding, skills and abilities in these areas.*[20]

Based on a comprehensive review of the literature on both Indigenous child and Indigenous adult health inequity, the Statement identifies the professional factors that impact on that inequity. It identifies six 'factors':

> *Health professional factors play a role in creating and maintaining inequitable health care and health professionals can play a major role in their elimination.*[21] [22]
>
> *Unconscious bias*
> *Institutional racism*
> *Privilege*
> *Colonisation*
> *Intergenerational Trauma*
> *Culture and health care.*[23]

Further definition of these impacts and how they operate and the research and reports that led to their inclusion are provided in the Statement. These six 'factors' provide a core of the curated collection on cultural safety – a resource developed to assist Fellows meet this new CPD focus. Articles and resources across these themes have been gathered into the curated collection and will continually be updated.

[18] Royal Australasian College of Physicians. Professional Standard on Cultural Safety. Professional Practice Framework; Professional Standards, October 2022. Pg5
[19] Royal Australasian College of Physicians. Statement on Indigenous child health in Australia and New Zealand. Pg 6
[20] 'Ibid'. Pg 29
[21] Andermann A; CLEAR Collaboration. Taking action on the social determinants of health in clinical practice: a framework for health professionals. CMAJ. 2016;188(17-18) doi:10.1503/cmaj.160177 88
[22] Durey A. Thompson SC. Wood M. Time to bring down the twin towers in poor Aboriginal hospital care: addressing institutional racism and misunderstandings in communication. Intern Med J. 2011;42(1):17-22.
[23], Amended from the Royal Australasian College of Physicians. Statement on Indigenous child health in Australia and New Zealand. Pgs 17-20