From: [redacted] [redacted]
Sent: Tuesday, 15 November 2016 8:42 PM
To: medboardconsultation
Subject: Revalidation - Submission

To whom it may concern,

I am a General Practitioner working in a small town rural town. I provide an extensive range of GP services including private general practice, inpatient, emergency and obstetric services at our local hospital. I also work as a Medical Educator for a GP training organisation and am an examiner for our college.

My thoughts are as follows:

1. CPD programs should be run by individual colleges. CPD activities should only be approved if they provide high quality, unbiased medical education. CPD activities should be based on best practice and not provided by drug companies. CPD requirements for each triennium should be across a broad range of topics, with high emphasis on keeping up to date with disorders that provide a high disease burden to the community (eg COPD, diabetes). If doctors are to maintain fellowship with a college then CPD should be required across all areas, not just special interest areas.
2. There is a difference between not knowing and not doing. When creating criteria for identifying high risk groups, please consider looking at areas of poor or lazy practice. Some examples of this:
    * Practitioners who prescribe high numbers of S8 drugs. Or prescribe PBS drugs outside of the PBS approval. A patient receiving such service is unlikely to complain and it is very hard to prove if suspected by peers.
    * Over-investigation, such as CT for non-specific back pain with no red flags
    * High numbers of referrals for services that 'should' be within a practitioners scope. Such as referring to a gynaecologist for a PAP smear, or dermatologist for a standard skin check. This not only de-skills the GP, but also adds to the cost of health care.
    * High number of inappropriate GP referrals to emergency departments. Perhaps feedback or auditing from EDs about how many of a GP's referred patients require admission or services that could not have been provided by a GP in the community.
3. MSF already used by ACRRM as part of the fellowship assessment. It is a very useful tool. However, the doctor nominates who they wish to provide the feedback. If MSF is used, it is important to ensure that the feedback is honest. Also, it is also very easy to identify who wrote the comments, even though feedback is presented anonymously. Sadly the medical profession is known for bullying. If MSF is used, those providing feedback, especially to senior colleges, will need to be protected.
4. I am interested in doctors over 35 years of age being in an "at risk group". I confess I have not read the individual studies, however would be intrigued to know how this relates to age of fellowship. Surely a specialist in any field, who takes responsibility for the patient's care and is now able to practice independently will attract more offical complaints than a non-fellowed doctor who is fully supervised in a hospital setting and is not the admitting doctor.
5. Currently, in general practice, doctors are allowed to practice in "GP Clinics" that are not Fellows of either GP college or in a recognised training program. When a patient presents to a clinic to see a GP, there is an assumption that the doctor they are seeing has obtained some form of minimum level of competence. There should be greater transparency and education to allow patients to make informed decisions about the doctor they choose or mandatory Fellowship (or recognised training) for these doctors to be allowed to practice. No other speciality allows non-fellowed doctors (or those not on a recognised training program) to practice and 'advertise' themselves as equals to fellowed practitioners. Some doctors are in 'supervised practice'

however the current level of supervision ratios required for limited registration doctors (1:4) is less than that on recognised training programs who have general registration (1:2). (see http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Supervision.aspx)

In addition, my non-medical spouse wishes to add:

The general public has poor access to necessary information to determine a doctor's various levels of qualifications. At present AHPRA maintains a register of doctor's bachelor and fellowship level qualifications, and information regarding their registration with AHPRA.

Many doctors claim to have a special interest. As a member of the general public, how am I to search for a doctor with a particular interest, or verify that they have any qualifications (outside bachelor and fellowship level qualifications, e.g. diploma & certificate level qualifications, or even courses such as ALSO, EMST etc.) pertaining to this interest? I understand that creating a central register of such information would be a large task, however the transparency, availability and searchability of such a database would be of high value to practitioners and the general public.

Thank you for reviewing this submission.

Kind regards,

[redacted] FACRRM