PG13 (PM) Guideline on return to pain medicine practice for specialist pain medicine physicians 2023

Short title: Return to practice – pain medicine

1. INTRODUCTION

Pain medicine encompasses a broad spectrum of practice in a sociopsychobiomedical framework, incorporating pharmacotherapeutic, psychotherapeutic, procedural and communication skills in varying combinations. Performance of clinical tasks at optimal levels depends on recent practice and deteriorates when there is an interruption at a rate that is related to a number of factors including duration of the interruption, duration of specialist practice prior to the interruption and cognitive changes associated with ageing or illness. As there is much individual variation in the impact of these factors, return to practice programs should be tailored to the individual's needs.

2. PURPOSE

These guidelines are intended to advise specialist pain medicine physicians (SPMPs) whose absence from clinical pain medicine practice does require or will require a formal return to practice program. Their purpose is to guide SPMPs and those assisting them to develop, monitor and successfully complete such a program. The overall aim is to ensure that the returning SPMP provides safe and up-to-date clinical care. The responsibility for this falls to the individual SPMP.

Both the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) have return to practice requirements. Although there are significant differences between them, there is enough consistency to allow FPM to develop one version of PG13 (PM). The jurisdictional requirements for Australia and Aotearoa New Zealand are outlined in Appendix 1.

3. SCOPE

This document applies to all SPMPs, whether in procedural or non-procedural practice, irrespective of the reason for their absence from practice. It applies to both mandated and voluntary return to practice programs. Return to practice programs may be mandated by jurisdictional authorities, employers, or institutions. In the absence of such a mandate from another body, compliance with any return to practice program is voluntary but strongly recommended.

4. BACKGROUND

Absences from clinical practice occur for a variety of reasons, including prolonged recreational leave, family commitments, practice in another area of medicine, practice overseas in a health service that is markedly different from that in Australia or Aotearoa New Zealand, or return from 'retirement' or illness.

Where an absence has occurred as a result of jurisdictional determination, such as suspension of registration, the faculty may be requested by the jurisdictional authority to endorse the practitioner's return to practice program plan. In such cases, it is the jurisdictional authority that gives final approval of the return to practice plan for the purposes of registration, not the faculty.

It is acknowledged that return to practice may be a stressful period, and it is suggested that personal and/or professional support be sought. Return to practice can be facilitated by maintaining regular professional contact with colleagues such as at group or departmental meetings, or CME events, and regularly updating knowledge during periods of absence from practice. If an absence from practice can be anticipated a plan for return should be considered at this time. It is important to retain records of any CPD activities completed within the period of absence.

This will aid in attaining currency of practice and facilitating interactions with colleagues during this time. For those returning to practice in Australia, maintaining their CPD requirements will assist in meeting the Medical Board of Australia (MBA) Recency of practice registration standard.

The onus for determining the clinical competency of SPMPs re-entering clinical practice after an extended period of leave lies with the SPMP, their employer and the Medical Board.

The FPM may provide the following assistance to a SPMP who is planning to take leave of absence from practice or to re-enter practice:

- Guidance on the process to follow when contemplating a planned absence and re-entry.
- Advice with respect to CPD requirements at the time of re-entry.
- Assistance in the development of a learning plan for re-entry.
- Advice with respect to suitable educational activities.
- Assistance with finding a suitable mentor and/or supervisor.
- Support for the nominated mentor and/or supervisor.

5. FACULTY OF PAIN MEDICINE RETURN TO PRACTICE PROGRAM

5.1 Recommendations

Both the MBA and the MCNZ mandate a formal return to practice program after an absence of 36 months. In Australia, if the period of non-practice is between 12 and 36 months, there is no such requirement for a plan, but rather completion of one year's relevant CPD activities is required. However, in this situation, the FPM recommends that a return to practice plan be drawn up (and followed).

This does not apply to pain medicine trainees, as absences will be addressed for them under the training program in by-law 4 Faculty of Pain Medicine Training program.

5.2 Principles

The return to practice program should be based on the FPM roles in practice (see the ANZCA and FPM CPD program).

- The program should incorporate the ANZCA and FPM CPD program philosophy.
- A needs analysis should inform the return to practice program.
- Significant concerns about clinical practice during the return to practice program should be managed in accordance with hospital policies and procedures, and relevant regulatory requirements.

The duration of a formal return to practice program will be determined by the learning needs analysis. The starting point for calculating the duration is one month per year of absence from pain medicine practice. The duration and components of the program may be varied, depending on the learning needs analysis and progress with the program.

5.3 Outline

In order to gain FPM endorsement of the planned program, the following framework must be followed where return to practice has been mandated and may be of assistance to those undertaking a voluntary return to practice

Stage 1: Supervised practice

- A period of workplace-based supervision, informed by the learning needs analysis, followed by;
- a structured assessment of ability to practice without workplace-based supervision using ANZCA and FPM CPD program peer review of practice format.

Stage 2: Practice evaluation

To be undertaken after successfully moving beyond workplace-based supervision and prior to completion of the return to practice program:

- A period of oversight by the supervisor; and

- A practice evaluation activity as outlined in the ANZCA and FPM CPD standard/program, such as multisource feedback (MSF) (4PM multisource feedback or 4PPM procedures multisource feedback), peer review (procedures or non) or an audit of clinical care outcomes, at least once, and more often as indicated by any gaps identified.

- Regular discussion of cases with the supervisor (or nominee). During the period of return to practice, the SPMP should maintain a logbook of cases to facilitate this case discussion.

- Additional requirements for re-endorsement in procedural pain medicine, as determined by the learning needs analysis

Stage 3: Completion
At the satisfactory completion of the program, the primary supervisor will submit a written report to the Faculty. If the named supervisor is unable to confirm satisfactory completion of the return to practice program, the program should be extended until satisfactory completion can be confirmed.

FPM will then endorse the SPMP as having satisfactorily completed a return to practice program.

5. RETURN TO PRACTICE PROGRAM DOCUMENTATION

For a return to practice program to be formally endorsed prospectively by FPM, it must include a written plan containing the following information:

- Reason for absence from practice,

- A learning needs analysis (using the framework for developing a CPD plan), developed following self-assessment and discussion with the primary supervisor, and goals of the program.

- Name of primary supervisor, other supervisors and the unit(s) within which the program will occur

- A description of the unit(s) within which the program will occur, the intended duration and timeframe of the program and details of the clinical experience to be undertaken during the program,

- The program details as outlined above in stages 1-4 of the return to practice outline.

For SPMPs practising in Aotearoa New Zealand – use the relevant regulatory authority template, guided by Appendix 2: *Guide to completing MCNZ template for returning to practice*.

For SPMPs practising in Australia – use the template *Return to pain medicine practice plan - for SPMPs practising in Australia* provided in Appendix 3.

Accompanying documentation:

- The agreement with the supervisor and department head / chair of the credentialing committee (or other person in a similar role).

- Written confirmation from their treating doctor that the practitioner is fit to practise if absence from practice was due to health and/or fitness issues

6. COMMUNICATION WITH FPM

The DPA FPM is available for advice about return to practice programs and FPM endorsement of programs. They may be contacted via the Faculty office (fpm@anzca.edu.au) and SPMPs are encouraged to do so.

This document is accompanied by a background paper (PG13 (PM) BP) which provides more detailed information regarding the rationale and interpretation of the Guideline.

REFERENCES

1. Medical Board of Australia. Registration Standard: Recency of Practice. October 2016. Available at https://www.medicalboard.gov.au/registration-standards. Accessed November 2022.
2. Medical Board of Australia. Plan for professional development and re-entry to practice. February 2016. Available at https://www.medicalboard.gov.au/codes-guidelines-policies/faq.aspx . Accessed November 2022.
3. Medical Board of Australia. Registration standard: Professional indemnity insurance arrangements. January 2016. Available at https://www.medicalboard.gov.au/registration-standards. Accessed November 2022.
4. Medical Board of Australia. Registration Standard: Continuing Professional Development (effective date 1 January 2023). Available at https://www.medicalboard.gov.au/registration-standards Accessed November 2022
5. Medical Council of New Zealand. Policy on practising certificate applications for doctors who have not held a New Zealand practising certificate or lawfully practised medicine within the previous 3 years. March 2021. Available at https://www.mcnz.org.nz/registration/maintain-or-renew-registration/restoration-to-the-register/ Accessed November 2022
6. Medical Council of New Zealand. Practice intentions. Form APC2 September 2019. Available at https://www.mcnz.org.nz/assets/Forms/APC2-Practice-Intentions.pdf Accessed November 2022.
7. Australian and New Zealand College of Anaesthetists. PG50(A) Guideline on return to anaesthesia practice for anaesthetists 2017. Available at https://www.anzca.edu.au/safety-advocacy/standards-of-practice/policies,-statements,-and-guidelines accessed November 2022.

ANZCA AND FACULTY OF PAIN MEDICINE PROFESSIONAL DOCUMENTS

POLICY – A document that formally states principle, plan and/or course of action that is prescriptive and mandatory.

STATEMENT – A document that describes where the college stands on a particular issue. This may include areas that lack clarity or where opinions vary. A statement is not prescriptive.

GUIDELINE – A document that offers advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus. A guideline is not prescriptive. Note that, in contrast to policy, guidelines use “should” (advises) and avoid “must” (mandated).

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this policy document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the College and Faculty endeavours to ensure that documents are as current as possible at the time of their preparation, they take no responsibility for matters arising from changed circumstances or information or material that may have become available subsequently.

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APPENDIX 1

JURISDICTIONAL REQUIREMENTS

Medical Board of Australia requirements

A SPMP re-entering practice in Australia must adhere to the Board's 'Recency of practice', 'Continuing professional development' (CPD) and 'Professional indemnity insurance' standards.

(a) Recency of practice standard
To meet this standard, a SPMP must practise within their scope of practice for a minimum total of:

- four weeks full-time equivalent (152 hours) in one registration period; or
- 12 weeks full-time equivalent (456 hours) over three consecutive registration periods.

'Full-time equivalent' equates to 38 hours per week and is the maximum number of hours that may be counted in a week.
A SPMP who has been practising in a jurisdiction outside Australia will meet the 'Recency of practice' standard provided they:

- have not been absent from practice for a year or more
- are not intending to change their scope of practice.

When a SPMP who has been absent from practice and is not registered or is registered as non-practising for more than one year is applying for registration, the Board will consider:

- registration and practice history
- when the practitioner last practised and the period of absence
- the number of years of experience prior to leaving practice
- activities related to the practice of medicine undertaken since they last practised (this includes CPD, education or professional contact)
- intended scope of practice, including the proposed role and position.

For a SPMP with two or more years of clinical pain medicine experience and now returning to practice, the Board has additional requirements based on whether they have practised or not during the period of absence:

- If they have not practised for up to and including 12 months, there are no additional requirements before re-entering.
- If they have not practised for between 12 months and up to and including 36 months, the minimum
  requirement is to complete the equivalent of one year's CPD activities relevant to the SPMP's intended scope of practice, before re-entering practice. These activities must have been with respect to maintaining and updating knowledge and clinical skills.
- If they have not practised for more than 36 months, a plan for professional development and re-entry to practice must be provided to the Board for consideration and approval. The SPMP will have to work under supervision for a designated period of time (as determined by the Board). Consequently, a supervisor (who has agreed to undertake the supervisory and support role and report to the Board) must be nominated

(b) CPD standard

To meet this registration standard, in each calendar year you must:

- meet the requirements of a CPD program of an accredited CPD home
- develop a written annual professional development plan
- complete a minimum of 50 hours per year of CPD activities that are relevant to your scope of practice and individual professional development needs
- allocate your minimum 50 hours per year between the following types of CPD activities:
  - – at least 12.5 hours (25 per cent of the minimum) in educational activities
  - – at least 25 hours (50 per cent of the minimum) in activities focused on *reviewing performance* and *measuring outcomes*, with a minimum of five hours for each category, and

        - – the remaining 12.5 hours (25 per cent of the minimum), and any CPD activities over the 50-hour minimum across any of these types of CPD activity.
    - self-evaluate your CPD activity at the end of the year as you prepare your professional development plan for the next year
    - retain records of your annual CPD activity for audit by your CPD home and the Board for three years after the end of each one-year cycle.

(c) Professional indemnity standard

A SPMP practising as a medical practitioner must ensure they are insured or indemnified for every context in which they practise. This applies to all practice contexts, including private and public practice, self-employed practitioners, those employed or contracted by others or working in an unpaid or volunteer capacity.

Medical Council of New Zealand requirements

For SPMP returning to work in Aotearoa New Zealand they must adhere to the MCNZ's Restoration to the register policies.

Requirements for doctors applying for a practising certificate after 3 years or more
For any application to which this policy applies, the applicant must provide the following information:

- a CV, with explanations for all gaps of 3 months or more.

If the applicant has practised overseas for more than 3 years, they must also provide:

- certificates of professional status or letters of standing;
- at least three satisfactory references, which meet Council's reference policy.

If the applicant has not practised at all for more than 3 years, they must also provide:

- a practice intentions form;
- evidence of any participation in recertification activities, including continuing professional development (CPD);
- a detailed return to practice and orientation, induction and supervision plan; and if the doctor is going to practise medicine clinically, the supervision plan should include time as an observer (up to one week, at the discretion of the Registrar)

A doctor who in the last 3 years has not practised in comparable health systems for at least 24 months for at least 30 hours per week:
Conditions will require that the doctor must:

- work under the supervision of a named, senior colleague registered within the same or similar vocational scope of practice
- only work in an approved capacity and place of employment
- provide us with supervision reports after 1 month, 3 months and every 3 months subsequently.

The required supervision period is 6 months of full-time equivalent satisfactory supervised practice.

A doctor who in the last 3 years has not practised medicine in any capacity.
Conditions will require that the doctor must:

- work under the supervision of a named, senior colleague registered within the same or similar vocational scope of practice
- only work in an approved capacity and place of employment
- provide us with supervision reports at the intervals specified in the following table.
- if returning to clinical practice: achieve advanced cardiac life support (ACLS) certification at the level required within 3 months of resuming practice in Aotearoa New Zealand. The required supervision period is dependent on the time out of practice.

Between 3 and 5 years out of practice and where satisfactory CPD has been completed
The doctor must:

- complete 6 months FTE of satisfactory supervised practice
- provide a supervision report after 1 month, 3 months, and every 3 months subsequently.

Either: between 3-5 years out of practice and satisfactory CPD has not been completed; or between 5 and 10 years out of practice

The doctor must:

- complete 12 months FTE of satisfactory supervised practice
- provide a supervision report after 1 month, 3 months, and every 3 months subsequently.

APPENDIX 2

Guide to completing MCNZ template for returning to practice for specialist pain medicine physicians practising in Aotearoa New Zealand

Medical Council of New Zealand (Practice intentions form - APC2)

- Section 1, “continuing medical education”, should list professional development activities as in the ANZCA CPD Program, namely:
    - Practice evaluation,
    - Knowledge and skills,
    - Emergency responses.
    -
- Section 2, proposed employment, should detail:
    - Proposed workplace: Name and type of institution (public, private, whether accredited for FFPMANZCA training, and if so, for how many years),
    - Proposed work role: title of post (e.g. fellow position, specialist), and whether an employee or an independent contractor,
    - Proposed scope of practice will be pain medicine,
    - An attachment should include the weekly proposed work plan including the hours of work and the types of work (e.g. procedural operating lists with specialties, acute pain rounds), and on call commitments if any.
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- Proposed CME should list professional development activities as in the ANZCA and FPM CPD Program, namely:
    - Practice evaluation,
    - Knowledge and skills,
    - Emergency responses.
    -
- Section 4, attachments, the “supervision plan” should specify:
    - Planned duration of workplace-based supervision,
    - Planned duration of oversight following workplace-based supervision, and whether on-site or by telephone.
    - Assessments to be undertaken during supervision period:
        - Structured assessment of the ability to practice without workplace-based supervision (using CPD Program (appendices 7,8,9) – proposed date and assessor,
        - Multisource feedback using CPD Program (appendices 4, 5) - number and proposed date,
        - Clinical audit – topic(s) using CPD Program (appendices),
        - Case-based discussion(s) – using CPD Program (appendix 11) as a guide.
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    - Details of action to be taken if: The learning needs are not satisfactorily met within the anticipated time frame,
    - Concerns about safety to practise arise.