FPM
Faculty of Pain Medicine
ANZCA

PG13 (PM) BP Guideline on return to pain medicine practice for specialist pain medicine practitioners

Background Paper 2023

Short title: Return to practice – pain medicine BP

1. BACKGROUND

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.

Returning to work can be stressful for the physician, regardless of the reason for the absence. Consideration of an individual's personal, and psychological or social needs is an important adjunct to organisation and workplace requirements in any return to practice program.

2. REVIEW OF ISSUES CONSIDERED (BASIS AND LIMITATIONS OF EACH RECOMMENDATION)

2.1 All reasons for absence will be covered, and the same overall process recommended for all specialist pain medicine physicians in both Australia and Aotearoa New Zealand

There are a variety of reasons for absence from pain medicine practice, such as illness, working exclusively in another speciality area, parental leave, social circumstances, employer-directed and regulatory authority mandated. This guideline will focus on meeting the individual needs identified in the needs analysis for successful return to pain medicine practice, rather than the reasons for that absence, although the reason for the absence will inform the needs analysis.

Written confirmation of fitness to practice will be required after absence due to significant illness that could affect the specialist pain medicine physician's (SPMP) fitness to practice. This is because of Faculty's purpose to promote safe and high-quality patient care and also because some illnesses can affect the abilities and skills required for safe patient care.

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).

2.2 Participation in a re-entry program is strongly recommended but is not mandated by FPM

FPM will assist returning SPMPs to meet the requirements of the regulatory authorities in their respective countries.

The MBA has mandated participation in a return to practice program, in Australia, after one to three years absence depending on duration of experience prior to absence, and the MCNZ after three years absence in Aotearoa New Zealand. The full details of their requirements are provided in their policies / standards. The regulatory authorities control medical registration and thus are able to enforce participation. FPM does not have comparable powers.

A voluntary scheme for those not subject to the regulatory authority rules is in keeping with FPM's philosophy of supporting Fellows.

FPM will provide endorsement of an individual program which complies with PG13(PM) if asked to do so by a regulatory authority, employer or an individual anaesthetist.

2.3 This guideline applies to SPMPs in independent practice and does not apply to trainees or SIMGs

Return to pain medicine practice for FPM trainees is not covered by PG13(PM) but is rather part of the FPM by-laws.

2.4 FPM recommends a return to pain medicine practice program after an absence of 12-36 months from pain medicine practice (depending on scope of clinical practice).

The mandated regulatory authority policies / standards mentioned above apply across all areas of medical practice. Most other Australian and Aotearoa New Zealand colleges require a return to practice program after three years absence, with a few after two years absence. Some have reproduced the MBA standard in their policies.

The relevant evidence such as the requirements of other like bodies, the paucity of good scientific evidence, the variation between SPMPs skills, abilities and reasons for absence, and the fact that regulatory bodies' policies / standards cover all types of medical practice was considered.

2.5 The FPM guideline will explicitly refer to the regulatory authorities' standard/policy on return to practice, and will be consistent with that standard/policy

As noted above, although there are significant differences between the MBA and MCNZ policies / standards, there is enough consistency for both to be addressed within one version of PG13(PM).

2.6 Documenting the return to practice plan

Both the MBA and MCNZ have templates for medical practitioners registered in their countries to use for their return to practice program documentation. While the two templates differ, there is significant consistency between them. However, different documentation will be used for Australia and Aotearoa New Zealand.

2.7 The return to practice program can be undertaken in a variety of settings

SPMPs practice in a variety of settings, which include multidisciplinary units accredited for FPM training, units not accredited for FPM training, and private practice. While there may be a view that a unit with experience in training and assessing pain medicine trainees is desirable for return to practice programs, such a setting is not mandatory, and may also pose access difficulties for an SPMP normally practicing in a non-FPM accredited setting. It is appropriate that the return to practice program occurs in the setting in which the SPMP will continue working following program completion. However, the setting will be taken into account in the needs analysis and program development.

2.8 The return to practice program will be underpinned by the philosophy of the ANZCA and FPM CPD standard and use the tools of the ANZCA and FPM CPD Program

The ANZCA and FPM CPD Standard and Program are applicable to practicing SPMPs, and thus are suited to SPMPs returning to pain medicine practice. They have the tools such as CPD planning, multisource feedback (MSF) and peer review of practice that are appropriate for a return to practice program.

2.9 The duration of the return to practice program will be determined by the learning needs analysis

No minimum duration of a return to practice program is specified. The starting point for determining the duration of a return to practice program should be four weeks per full year of absence from pain medicine practice. However, the duration of the program and its components would then be shortened or lengthened depending on the learning needs analysis and progress in the program.

2.10 The content of the return to practice programs will include:

2.10.1 A period of workplace-based supervision

2.10.2 A structured assessment of ability to practise without one-on-one supervision using the ANZCA and FPM CPD peer review of practice format. This is to provide assurance of safe practice, and to allow variation in the time spent under supervision depending on the learning needs analysis and progression in the return to practice program.

2.10.3 A period of practice under the supervisor's oversight and monitoring. During this period evaluation should include regular MSF and practice evaluation activities, to monitor the outcomes of the return to practice program.

REFERENCES

1. Australian and Aotearoa New Zealand regulatory authority policies on practice re-entry:

a. 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

b. Medical Board of Australia. Registration Standard: Recency of Practice. October 2016. Available at https://www.medicalboard.gov.au/registration-standards. Accessed November 2022. 2. 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.

3. Attoe C, Matei R, Thompson L, et al. Returning to clinical work and doctors' personal, social and organisational needs: a systematic review. BMJ Open 2022;12:e053798. doi:10.1136/ bmjopen-2021-053798

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.

POSITION 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).

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Promulgated: 2023

Date of Current Document: 2023

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