

25 October 2017



The Honourable Dr David Clark  
Minister of Health  
Parliament Buildings  
**Wellington**

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Dear Minister

On behalf of the Medical Council of New Zealand, please accept my warmest congratulations on your appointment as Minister of Health.

The Medical Council of New Zealand (Council) is tasked by the Health Practitioners' Competency Assurance Act 2003 (the Act) to protect public health and safety by ensuring doctors are competent and fit to practise.

Council is active in a number of strategic areas. Council would welcome an opportunity to discuss these matters with you.

## **1. New Zealand health strategy**

Council notes the recently revised New Zealand Health Strategy with its five key themes. Much of our work is well aligned with the principles of the health strategy. In particular, Council contributes to the strategy via work to ensure we represent the needs of the public; a central component of this being to ensure doctors are competent for practice and that this competence includes the skills necessary for a multi-disciplinary approach to health care delivery.

We acknowledge the considerable opportunities technology can offer in delivering safe and effective care close to the patient's own environment. Council is working closely with educational providers to ensure training reflects the needs of the strategy.

Council has also directed much effort toward reduction in health inequity.

## **2. Recertification and maintenance of competence**

Council recognises five main groups of clinically active doctors:

- i. Interns - doctors in Post-Graduate Years 1 & 2 (PGY-1 & 2).
- ii. General registrants not in accredited specialist training programmes.
- iii. General registrants actively engaged in accredited specialist training programmes.
- iv. Specialists on the vocational Register.
- v. Doctors with a special purpose registration eg, locum specialists from overseas; visiting experts etc.

Every practising doctor must engage in Continuing Professional Development (CPD), which is also referred to as recertification (please note - many overseas jurisdictions use the term "Revalidation". It should be viewed as interchangeable with "Recertification"). Council, in recent years, has significantly strengthened recertification for those general registrants *not* in a training programme,

as this was an area of particular risk. This strengthening has been via the introduction of the *Inpractice* programme.

Interns are all required to work in accredited training positions and the introduction of the New Zealand Curriculum Framework has added significant value to their education and career-planning.

Council is currently strengthening the recertification requirements of vocationally registered doctors. This work will continue through 2018 and is designed to raise the consistency and value of CPD programmes in all colleges. In 2016, colleges and other stakeholders strongly endorsed Council's decision to introduce Principles-based requirements for CPD. These principles will overarch each college programme.

The Medical Board of Australia (MBA) is currently considering strengthening its revalidation requirements. The MBA is considering a risk based approach that would see added requirements for doctors in certain categories such as age and isolated practice. Whilst acknowledging age and clinical isolation do increase risk we as yet see no clear evidence to target doctors based on simply being of a particular age. Work on risk stratification to identify doctors at increased risk of competence concerns is continuing internationally and the Council will continue to actively review this issue as evidence is accumulated.

We have adopted an educative approach via our principles based work. Clinical isolation has been well highlighted in our strategic work and we believe the risk of this and ways to mitigate this risk are best addressed via peer support and open discussion.

An evidence based approach to CPD is essential to maximise the educational value of any programme. Such value should ultimately improve care for patients. Council is acknowledged as an international leader in this work. Via the *Inpractice* programme for general registrants, we are gathering considerable evidence as to the benefits of Regular Practice Review, an activity whereby a doctor is visited by a peer in their usual place of work to observe and interact with the doctor. Part of the interaction is to discuss plans for learning. Independent prospective analysis of the visits shows sustained benefit.

A significant feature of best-practice in CPD is reflection of a doctor's practice based on reliable data. Council supports initiatives to engage with clinicians to identify the types of data that would be of benefit in Recertification activities. These data will vary by scope of practice and by individual practice within a scope. Council is aware of various calls for the public release of data and we call for caution in this regard so as not to undermine public confidence in the health system. Council stresses the importance of context with any data release and the risks of "league tables" cannot be overstated.

Good data are, however, central to informed choice for patients. Council supports calls for doctors to have ready access to outcome data that will aid decision making by both clinicians and patients. Such data need to be relevant to the New Zealand system and therefore allow clinicians to benchmark with greater confidence than relying on international data.

### **3. Accreditation processes**

Council accredits all colleges who provide vocational training in New Zealand, and we also accredit both medical schools. Given the bi-national nature of many colleges and the desire for consistency

of vocational and undergraduates in Australia and New Zealand, we work closely with the Australian Medical Council on both college and university accreditation.

In addition, Council accredit all DHBs for the intern programmes they provide. This is conducted on a 3-year cycle. All accreditation programmes are measured against published standards. Where providers are found to have not met a standard, Council requires corrective action. All accreditation reports become publicly available once the report is approved by Council.

We work closely with educational and clinical supervisors and Chief Medical Officers in each DHB to ensure intern education and training is effective; assessment of this effectiveness is a core feature of DHB accreditation. The introduction of the New Zealand Curriculum Framework and the electronic support ("ePort") is a significant advance.

#### **4. Cultural competence and reduction of health inequity**

Council has a long-established requirement for all doctors to be culturally competent. In 2016, we introduced a new strategic goal designed to lead the profession in addressing health inequity. There is clear evidence that some aspects of health inequity can, and should, be significantly influenced by the profession. Council has entered into a partnership with the Māori Doctors' organisation, Te ORA, to further work in this area. Progress to date is encouraging, but many challenges remain. We are, however, confident that the profession has a strong desire to reduce inequity where possible.

An important feature of this work is supporting Māori students and recent graduates to consider vocational training as there is currently a disproportionately low number of Māori doctors on the vocational register. For the first time in New Zealand's history the proportion of medical students identifying as Māori is mirrored by the proportion of the general population who so identify. This is a significant achievement by the medical schools, and one that must be capitalised on by the colleges and the wider health sector.

Much work remains to be done but the initial reaction by colleges to this opportunity has been encouraging.

#### **5. Workforce planning and community based attachments**

Council works closely with Health Workforce New Zealand and relevant stakeholders on various aspects of workforce planning. Whilst Council is not an employer of doctors, our legislative responsibilities around registering competent doctors and protecting public health and safety mean we must be involved in processes regarding wider workforce issues.

Council has long recognised the need for new graduates to receive a broad exposure to clinical opportunities both within and outside the traditional secondary care settings. To this end, we removed the mandatory attachment requirements that limited PGY-1 doctors to only medical and surgical attachments and we have introduced a mandatory Community Based Attachment (CBA).

The widening of attachment opportunities has led to a broader internship. The CBA programme is exposing graduates to clinical practice outside the hospital. Approximately two-thirds of CBAs are in general practice with the remaining one-third in a variety of settings including urgent care, community mental health, community paediatrics, aged care, hospice care, and integrated care.

A fundamental aim of the CBA programme is to not only show new graduates how medicine is practised in the community, but to also stimulate thinking about how it *could* be practised.

The programme will see approximately 33% of interns achieve a CBA before the conclusion of their PGY-2 year by the end of 2017. Council is working with DHBs to ensure DHBs meet their requirement that all interns have a CBA by 2020.

The CBA faces some challenges. Capacity, especially in general practice, remains a challenge as we must not interfere with university placements for clinical students, both medical and other.

Most DHBs are performing well in the development of CBAs, but there is resistance in some. We do have particular concerns about some areas of the country. Council has considerable concern about the logic and accuracy of recent modelling work done by DHB Shared Services that suggests the CBA programme cannot be achieved without undue burden on DHBs. Council's concerns regarding the modelling are shared by all other stakeholders.

The programme has received considerable support from Health Workforce New Zealand and from stakeholders including the Resident Doctor's Association, both medical schools, and the General Practice and Urgent Care colleges.

The Resident Doctor's Association (RDA) has worked closely with DHBs to ensure growth in CBAs, both in number and value. The RDA has also conducted a survey of those doctors who have had a CBA – the results are overwhelmingly positive and the programme is leading to an increased uptake of training in general practice.

The Government has indicated a significant increase in funding for general practice training. This is a very important and much welcomed step; however, we know from medical school data that only a relatively small proportion of undergraduates consider general practice as a career. This indicates a vital need to continue to expose newly graduated doctors to community focused practice.

Council would support a requirement for DHBs and PHOs to actively engage in workforce planning. Furthermore, Council would encourage the Minister to consider making workforce planning and compliance with Council's CBA programme core requirements of all DHBs in their annual work.

## **6. Preparation for practice**

Council has close links with both Otago and Auckland Medical Schools and a Memorandum of Understanding has been developed to allow ease of transition of students to provisionally registered interns. Council is also working with stakeholders on the issues of clinical preparation including how prescribing could be safely introduced to the clinical programme. This is a challenging area but one where we believe safe advances can be made.

Both universities have engaged on the NZ Curriculum Framework and trainee interns are encouraged to access and use the system.

## **7. Telehealth**

Telehealth offers considerable opportunities for the safe delivery of health care services especially to those members of the community who cannot readily access some services. However, with these

opportunities come some significant challenges, none more so than the issue of unregistered providers in off-shore jurisdictions.

Council cannot mandate registration on overseas-based providers nor can we conduct our normal competence or conduct processes if concerns arise with an overseas provider. At present, legislation such as that covering the dispensing of medicines adds a level of safety for the public, but Council is concerned that some providers of health services in New Zealand may further engage telehealth providers based off-shore.

To maintain safety standards Council believes contracts entered into by New Zealand based organisations, including DHBs, must include requirements for the vetting of service providers via similar processes we currently have for international medical graduates seeking vocational registration in New Zealand, as well as for the on-going review of the performance of overseas-based providers.

In addition, Council believes a provision for the termination of such contracts must be present if Council cannot be assured of acceptable standards of competence or conduct.

Council has recently reviewed our Telehealth statement to ensure it is not a barrier to innovative practice.

## **8. Legislative issues**

The Act is achieving its stated purpose of protecting public health and safety, however Council does support a number of amendments.

Council requests amendment to Section 69 to allow for immediate suspension in cases where Council believes a doctor's practice poses a clear risk to public health and safety and lesser mitigating steps cannot reliably be taken to assure public safety.

At present, Council must propose suspension and allow "reasonable time" for the doctor to respond. Council must then consider the response and then elect to impose the suspension if Council believes it is still warranted.

Council believes amendment to allow immediate suspension would significantly enhance public safety, albeit with a requirement for Council to urgently consider the doctor's submission, and with retention of the doctor's existing legal rights to challenge the decision via the Courts.

Other amendments to allow discretion on referral of convictions to a Professional Conduct Committee and some further technical amendments about maintaining an accurate Register are also requested.

Council is aware of proposals to amend the Act to address multidisciplinary team work. Council fully supports a team based approach to much clinical care, but it is challenging for a Regulator to address competence of an individual if a concern arises within a multidisciplinary team environment. Council is actively exploring this issue.

Council has worked closely with Health Workforce on workforce related data. Council believes legislative changes would enable better data to be collected and used. At present, privacy issues are seen as a barrier to a complete data picture of the profession.

## **9. International medical graduates**

Council registers approximately 1200 international medical graduates each year. Depending on the background and experience of these doctors, some will be required to sit the New Zealand Registration Examination (NZREX). Council remains concerned that a moderate proportion of doctors who successfully pass NZREX cannot obtain an accredited position in which to enter clinical practice. Council is considering how we can expand opportunities for these doctors to safely integrate into the New Zealand health system.

A recent internal review shows that over the preceding 5 years, approximately 64% of doctors who passed NZREX did go on to gain employment and a Practising Certificate. This figure is greater than expected, but we must acknowledge it is difficult for NZREX graduates to begin clinical practice in New Zealand. Long-term data show that once these doctors become settled into practice, there are no significant differences in competence or conduct concerns compared with other doctors.

## **10. Very low-cost access scheme**

Council has noted the continued debate over the merits and problems of the VLCA scheme. Whilst funding for general practice is not part of Council's remit, funding obviously strongly influences access and effectiveness of care for the public.

It appears the unintended consequences of VLCA include the risk of losing some doctors especially from rural areas and thus Council does hold concerns for patient health and safety. Council will support any work the Minister may engage in to address these unintended consequences.

## **11. Council Executive leadership**

After leading the organisation for almost 12 years, the current Chief Executive, Mr Philip Pigou, is leaving to take on the role of Chief Executive of the Australian Medical Council in Canberra. The Council is currently engaged in recruiting a new Chief Executive.

I would welcome the opportunity to meet with you at your earliest convenience to discuss any of the issues referred to above or any other health sector matters.

Kind Regards



Andrew Connolly  
**Chair**

cc: Director-General of Health