

MEDICAL COUNCIL NEWS



Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

ISSUE 50 DEC 10

NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

www.mcnz.org.nz

CHAIRPERSON'S FOREWORD

Council's 360° performance review



EXTERNAL REVIEWS from time to time – on what you are doing well, what you can do better, and what you should stop doing – are very helpful in assuring quality.

With this in mind, the Medical Council of New Zealand asked the Council for Healthcare Regulatory Excellence (CHRE) to undertake a full performance review of our policies and processes. The review was carried out in March and April 2010.

The CHRE promotes the health and well-being of patients and the public in the regulation of health professionals in the United Kingdom (UK). It shares good practice and knowledge with regulatory bodies, conducts research, and introduces new ideas about regulation to the sector. The CHRE monitors the performance of all regulatory bodies in the UK.

For us, a major attraction of a performance review by the CHRE was the opportunity to have an independent assessment benchmarking our performance in relation to regulators in the UK. ►

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◀ THE PERFORMANCE REVIEW PROCESS

The review involved the following steps:

- working for a week at the Council’s office during April 2010, where staff provided further evidence and background information about the organisation, its policies, and processes
- auditing six fitness to practise cases chosen as a random sample by CHRE
- attending a ‘senior officers of Council’ meeting that considered and made decisions on nine possible fitness to practise cases
- attending meetings in New Zealand with people who had given third-party feedback, including representatives of the Health and Disability Commissioner (HDC) and the Health Practitioners Disciplinary Tribunal (HPDT)
- giving initial informal feedback to the chair, chief executive, and senior management team of the Council and considering their responses
- sharing a draft report with Council staff for comment
- completing and submitting the final report.

OVERALL ASSESSMENT

The CHRE report made the following comments.

‘We were impressed with many aspects of the approach to regulation that has been adopted in New Zealand. In particular, the philosophy of attempting to deal with concerns about fitness to practise in a collaborative, non-adversarial way appears to work effectively in protecting the public in the majority of cases. There are aspects to this approach that could usefully be applied by regulators in other countries.

Overall we report that the following areas of the MCNZ’s (Medical Council of New Zealand) work are particularly impressive:

- The comprehensiveness and quality of the standards and guidance documents.

- The approach to resolving fitness to practise concerns about doctors in a non-adversarial way with the intention of protecting the public quickly through rehabilitating the doctor back to effective practice.
- The proposals for strengthening the process of recertification of doctors. The proposals are focused on improving the quality of the profession and continue to build on the current processes and tools of competence reviews.
- The quality of relationships with the other bodies who have an interest in the regulation of doctors in New Zealand, although we are aware there has been some criticism of the MCNZ by the HDC in relation to one recent fitness to practise case.

There are also some areas where we consider that the MCNZ would benefit from exploring some of the practices of regulators in other countries, including the UK.

These areas include:

- Increasing the level of openness of its work particularly in decision making, in relation to the fitness to practise function and to the information that appears on its register. This includes publishing on the register more information about conditions imposed or voluntary undertakings (except health) agreed with doctors.
- Building better links with employers in relation to fitness to practise issues including more routine mutual exchange of information about doctors where there are concerns. However, we did note that the MCNZ is currently carrying out a review of the Memorandum of Understanding with District Health Boards.
- Developing a patient and public involvement strategy, and enabling patients and the public to have much greater engagement with all areas of the MCNZ’s work.
- Ensuring that when a doctor has demonstrated serious incompetence, and in particular where this might not be amenable to remediation, the case is dealt with as a conduct issue rather than through competence procedures. The MCNZ should have a greater regard to the impact on the public’s confidence in the profession when making all fitness to practise decisions.
- Developing a greater commitment to organisational diversity and equality issues, including ensuring that people are appointed to the Council and to its committees, including performance assessment committees, on the basis of fair and open competition, and against defined roles and competencies.
- Reviewing the composition of the Council and its committees, although the former would require legislative change, as would professional conduct committees. At present these have a majority of doctor members, but good

practice from the UK would suggest that at least parity of public membership is important in ensuring unbiased decision making and a focus on patient safety and in maintaining public confidence in regulation’.

THE WAY FORWARD

The report has provided valuable information for us to consider very carefully.

Council members and senior staff have discussed the report at length. We have agreed that our processes should be as open and transparent as possible, while retaining our overall rehabilitative and quality improvement philosophy to protect the health and safety of the public.

We have agreed that, as a general principle, information about our decisions should be publicly available when any formal order or direction has been made.

In considering the CHRE report, Council members agreed that:

- the names and public details of doctors who have been suspended from the register should be published in a way that can be easily accessed by members of the public
- the online register should include plain English explanations of what conditions on a doctor’s entry mean
- voluntary undertakings should only be used on an interim basis until orders and directions, including conditions, can be considered and applied (except in relation to health). Conditions are included on the online register
- where voluntary undertakings are used, these should remain confidential, except to the employer, partner, or person working in association with that doctor. Except as appropriate in health-related issues, notification to such people will be mandatory to help ensure the doctor’s compliance with the undertaking
- voluntary undertakings in relation to health should remain confidential except to the district health board or its chief medical officer, or the doctor’s supervisor, if relevant, or the partner or person working in association with that doctor
- all conditions should be reviewed as part of the monitoring process where the Health Practitioners Disciplinary Tribunal has published adverse findings, and there should be a link in the doctor’s entry on the online register to that finding
- complainants must be notified of the outcome of decisions made in relation to concerns they have raised. Such notifications should:
 - be by letter

- outline the reasons for sharing the information, and ask that it not be shared with third parties
- be made at the time a decision has been made (for example, once Council has considered the report of a performance assessment committee or professional conduct committee and made a decision).

PUBLIC ENGAGEMENT

With respect to public engagement, Council members agreed:

- to ask staff to document the Council’s current appointment processes for all Council agents and committee members. These processes were considered at our October 2010 Council meeting
- to issue media releases to advise the public and profession when it publishes new statements and resources
- to consider other matters relating to public engagement again, once other decisions have been implemented and their impact has been assessed.

YOUR FEEDBACK IS NEEDED

Our primary purpose is to protect patient health and safety by ensuring doctors are competent and fit to practise medicine. Often, the best way to achieve patient health and safety is through a rehabilitative approach with the individual doctor. Council agreed that it should continue to have a rehabilitative approach where appropriate, and that the openness of its processes should be balanced against the effect such openness might have on the rehabilitation of doctors.

We would like your feedback on the subject of openness and transparency before considering further changes, and, in particular, the proposal to publish information relating to education or recertification programmes.

The CHRE report, *Performance review of the Medical Council of New Zealand. Promoting improvement in regulation through international collaboration, June 2010*, can be downloaded from our website at www.mcnz.org.nz>>News and Issues



John Adams
Chairperson 

Understanding our registration processes

IN THE LAST ISSUE of *Medical Council News* (April 2010), we outlined our registration processes and what a 'proposal to decline' meant. In this issue of *Medical Council News*, we look at how we manage applications for registration within a vocational scope of practice.

WHAT MUST A DOCTOR DO TO QUALIFY FOR REGISTRATION IN A VOCATIONAL SCOPE OF PRACTICE?

To qualify for registration the doctor must:

- satisfy the Medical Council's English language test requirements
- be fit for registration (see section 16 of the Health Practitioners Competence Assurance Act 2003)
- be able to assure Council that he or she has qualifications, training and experience equivalent to, or as satisfactory as, that of a New Zealand trained doctor registered within the same vocational scope (see section 15(2) of the Health Practitioners Competence Assurance Act 2003)
- be capable of independent, unsupervised practice



- be competent to practise medicine within the vocational scope applied for
- be intending to practise in New Zealand.

The vocational pathway is not a training pathway for international medical graduates (IMG) to reach the standard required.

INTERNATIONAL MEDICAL GRADUATES APPLYING FOR REGISTRATION IN A VOCATIONAL SCOPE – WHAT'S INVOLVED?

The process of obtaining registration in a vocational scope of practice for IMGs is often a source of frustration to doctors applying for registration because of perceived time delays, incomplete applications, and requests for more information by Council staff.

The time needed to process these applications depends on the information provided. As a rule of thumb, we ask doctors applying for registration in a vocational scope to allow 6 months from the date we receive their complete application for a decision to be made. With this in mind, applications should be in the Council office well in advance of making employment or immigration arrangements, which may be affected by the outcome of any application.

SO HOW DOES THE IMG VOCATIONAL PATHWAY WORK?

In the first instance, we ask doctors to use the self-assessment checklists on our website for an indication of the New Zealand standards they will be compared to. If their training is comparable, they can then complete the correct application form and submit this to the Council office.

Registration staff obtain references directly from referees, along with relevant documentation, before sending it on to the branch advisory body (BAB) to assess. Delays will occur at this stage if the applicant does not ensure that their referee responds to this request quickly.

The BAB will carry out an initial paper assessment for doctors not in New Zealand. If the doctor is in New Zealand and considered to be suitable to proceed, they can go straight to an interview with the BAB without having a preliminary assessment.

Often it takes time to convene an interview panel because of the need to fit in with panel members' clinical or other commitments. The Council also requests advice from the BAB about suitability of the position and supervision for assessment. It is common for delays to occur here, particularly when job offers or supervision plans are inconsistent and do not distinguish between orientation and induction. Once the position and supervisor are endorsed by the BAB, the IMG may be allowed to start work pending the interview, but always limited to a particular institution and under very close supervision.

Following the interview, the BAB will then let the Council know whether or not it considers the doctor's training, qualifications, and experience are equivalent to, or as satisfactory as, that of a New Zealand trained doctor registered within the same vocational scope. The BAB will also advise what requirements the doctor needs to complete to qualify for registration within a vocational scope. Based on the advice received, Council members then make a decision on the application, and may resolve to approve registration through either:

- the supervision pathway (12 months continuous satisfactory supervised practice); or
- the assessment pathway (12 to 18 months continuous satisfactory supervised practice and any further requirements; for example, a vocational practice assessment; or working at a larger center.

WHAT HAPPENS IF A DOCTOR'S APPLICATION FOR REGISTRATION WITHIN A VOCATIONAL SCOPE OF PRACTICE IS DECLINED?

If the application does not satisfy the registration criteria, Council will propose to decline the application. The doctor is notified in writing and given the reasons for the proposal to decline.

The doctor is then given an opportunity to provide written submissions and be heard, either personally or by a representative, at one of the Council's scheduled meetings. This gives the doctor a final opportunity to provide information for the Council to consider before it makes a decision on the application.

At the Council meeting, members consider the information submitted with the application, the additional information provided by the doctor or their representative, and its policies. Council members use all this information to determine whether the applicant's training, qualifications, and experience are considered equivalent to, or as satisfactory as the prescribed qualification for registration. In addition, Council must decide whether the doctor is fit and competent to practise medicine in New Zealand in the scope of practice for which they have applied.

More information about registration within a vocational scope of practice can be found online at: www.mcnz.org.nz/Registration/Howtobecomearegistereddctor/Vocationalscope/tabid/86/Default.aspx or by emailing info@mcnz.org.nz 📧

Regular practice reviews now a reality



FOLLOWING CONSULTATION with the profession last year, we have started working with the professional colleges to implement regular practice reviews (RPR).

We are encouraging the profession to lead development of the RPR process. For those who are registered in a vocational scope, these processes are being made available as part of continuing professional development programmes through branch advisory bodies (BAB). RPR is not compulsory and is not required for recertification for these doctors.

We have agreed a set of principles for RPRs. The principles are:

- That RPR is a formative process. It is a supportive and collegial review of a doctor's practice by peers, in a doctor's usual practice setting.
- That the primary purpose of RPR is to improve the standards of the profession. RPR may also assist in the identification of poor performance which may adversely affect patient care. ►


- That RPR will be led by the profession with support and assistance from Council.
- That Council will encourage each BAB to develop a RPR process using specific tools relevant to that specialty. Alternatively they may expand upon existing BAB processes or tools that have already been developed by Council. The BABs will make the process available to doctors on a voluntary basis. Council will assess and provide feedback about the RPR process when accrediting a BAB continuing professional development programme.
- That RPR is informed by a portfolio of information provided by the doctor, which may include audit outcomes and logbooks.
- That a 360° assessment forms part of a RPR.
- That RPR must include some component of external assessment, that is by peers external to the doctor's usual practice setting.
- That the RPR must include a process for providing constructive feedback to the doctor being assessed.
- That the organisation responsible for undertaking the RPR must have a process for assisting the doctor in identifying and addressing learning needs.

We have been working closely with a number of organisations such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the New Zealand Orthopaedic Association, and the Royal New Zealand College of General Practitioners and would like to thank them for their support and involvement with the RPR concept.

Council is taking a different approach for doctors on a general scope.

For these doctors, Council is intending to strengthen recertification programmes, by requiring them to participate in a Council accredited recertification programme. This must include RPR being undertaken every 3 years, with the first practice review to be undertaken 3 years after the doctor achieves registration in a general scope of practice.

The Council will be seeking proposals from BABs and other interested organisations early in 2011 for the provision of recertification programs for general scope doctors.

If you would like more information about the RPR process please email Joan Crawford, our Strategic Programme Manager at jcrawford@mcnz.org.nz 

New and updated statements



CONFIDENTIALITY AND PUBLIC SAFETY

The Council has decided to withdraw its statement on *Confidentiality and public safety*. We have done so because this is an area that is the responsibility of the Privacy Commissioner and the recently released plain English commentary to the *Health Information Privacy Code* provides much more comprehensive advice on the subject as well as a list of relevant case studies.

A copy of the Commissioner's resource can be downloaded from www.privacy.org.nz/health-information-privacy-code-1994-with-commentary-link/.

DISCLOSURE OF HARM FOLLOWING AN ADVERSE EVENT

Recently we've made some amendments to our statement on *Disclosure of harm* (now called *Disclosure of harm following an adverse event*). These changes are relatively minor in nature, and most are intended to improve the readability of the document rather than change its content.

However, a new paragraph has been added (paragraph 26) to acknowledge that in some circumstances, such as where the patient has died or has been significantly compromised, disclosure will need to be made to a third party such as a family member. A further change is to include references to several new resources and publications that discuss disclosure of harm. These resources include the Health and Disability Commissioner's *Guidance on open disclosure policies* and a comprehensive handbook published by the United Kingdom's National Health Service called *Being open*.

We enclose a copy of the revised statement with this issue of *Medical Council News*.

NON-TREATING DOCTORS PERFORMING MEDICAL ASSESSMENTS OF PATIENTS FOR THIRD PARTIES

In June 2003 the Council produced a statement which outlines its expectations when doctors are employed by a third party to perform medical assessments of patients. We have recently reviewed this statement and made a number of amendments, including:

- Making the language more direct and simple.
- Ensuring that the recommendations are aimed at doctors, and not at third parties.
- Amending the section on 'effective communication and consent' to make clear that this only applies when a patient consultation is involved (and not, for example, when a doctor is asked to conduct a file assessment).
- Replacing the phrase 'clinical evidence' in paragraph 20 with 'relevant evidence', as this phrase has apparently caused some patients to assume that a physical examination is required.

We enclose a copy of the revised statement with this issue of *Medical Council News*.

PRESCRIBING DRUGS OF ABUSE

We have become aware of an error which appeared in the copy of the statement on *Prescribing drugs of abuse*, which was circulated with the last issue of *Medical Council News*.

Paragraph 5 of that statement omitted the words 'for treatment of dependency' when discussing the limits the Misuse of Drugs Act 1975 places on the prescribing of controlled drugs to dependent persons. We have placed a corrected version of the statement on our website, and this can be downloaded from www.mcnz.org.nz >> Resources

WHAT TO DO WHEN YOU HAVE CONCERNS ABOUT A COLLEAGUE

Doctors have an ethical responsibility to protect patients from risk of harm posed by a colleague's conduct, performance, competence, or health. Enclosed with this issue of *Medical Council News*, you will find a copy of our new statement on *What to do when you have concerns about a colleague*. This statement is intended to help you:

- understand where the threshold lies for acting on your concerns about a medical colleague's conduct, performance, competence, or health
- raise concerns
- understand what help and support is available to you. 📞

Dietitians prescribing special foods

The Council would like to thank the Dietitians Board for contributing the following article.

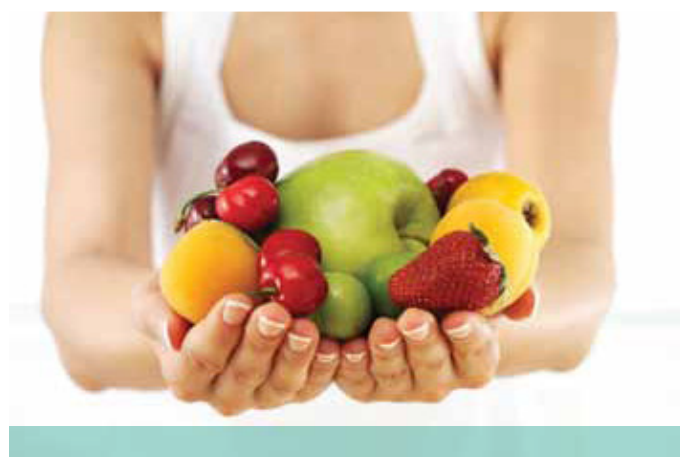
More information on this issue can be obtained from Jane de Lisle, Registrar of the Board, by emailing dietitians@dietitiansboard.org.nz. 📧

THE DIETITIANS BOARD and Dietitians New Zealand Inc have announced that PHARMAC has agreed to allow authorised (and currently practising) dietitians to prescribe special foods and oral vitamins and minerals and oral electrolyte solutions. Dietitian prescribing was added to the PHARMAC schedule published in August 2010.

Before dietitians can prescribe special foods and related products, they will need individual accreditation by the Dietitians Board, and must have the role of prescribing included in their annual practising certificate (APC).

Prescribing special foods is covered by the current scope of practice and will be controlled by an endorsement on the Dietitians Board register and on the APC. Dietitians will be required to undertake a training course to meet the Board's new criteria for prescribing which is currently being developed.

The Board hopes the first endorsements to APCs will start from 1 April 2011. The Dietitians Board will be responsible for the course content, accreditation, ongoing competence, and monitoring of 'prescribers'. 📞





Order your free statements pack

IN RECENT YEARS, the Council has produced over 30 statements on topics such as:

- informed consent
- best practices when providing care to Māori patients and their whānau
- unprofessional behaviour and the health care team
- cosmetic procedures.

As new standards and guidelines are produced, or others are updated, we will send them to you automatically with Medical Council News. A complete set of the Council's standards and guidelines can be obtained by emailing folder@mcnz.org.nz or phoning 0800 286 801 extn 793.

Statements are also on our website at www.mcnz.org.nz>>Resources 📄

Is your email address the right one?

DURING THE NEXT COUPLE OF YEARS the Council will be providing more of its services online, including using emails to communicate with doctors. Occasionally we may need to send an email containing confidential information to a doctor.

The email address you provide to the Council may be used to send confidential, personal, or private information about you or about other doctors. For this reason, you must give the Council an email address that is suitable for receiving confidential and private information.

If you would like to change the email address you have given us, you can update it:

- during your next practising certificate renewal on the application form
- online at www.mcnz.org.nz Registration>>Currently registered doctors>>Change your personal details
- by emailing mcnz@mcnz.org.nz. 📧

Lost doctors

IN THIS ISSUE OF *Medical Council News*, we list several 'lost' doctors. These are doctors we cannot trace because they have not let us know their new addresses.

If you change your address, please let us know your new address within a month.

You can change your address online at www.mcnz.org.nz>>Registration>>Currently registered doctors>>Change your personal details.

The following doctors will be removed from the medical register unless we receive their new addresses. If you know how to contact any of these doctors, please email apc@mcnz.org.nz or phone 0800 286 801 ext 785.

- Vatsa Bharatkumar Dave
- Imran Majeed Kayani
- Beth Jennifer La Brooy
- Stefania Roberts
- Adriane Jane Sinclair 📧

Helping international medical graduates integrate

FOR SOME TIME, the Council has wanted to understand the reasons behind the low numbers of international medical graduates (IMGs) staying in New Zealand.

As we have little information on why IMGs are leaving New Zealand, we asked Sue Ineson of Karo Consulting to undertake research on our behalf. She gathered information through an email survey of doctors applying for a certificate of good standing (CGS) before leaving New Zealand.

Several focus groups were held with doctors who had just arrived in New Zealand to find out what would have helped their acculturation and to identify any barriers to the recruitment and retention they experienced.

The email survey established that 50 percent of the doctors who responded never intended to stay in New Zealand for the long term.

The main barriers to retention that were identified relate to:

- lower remuneration rates
- family reasons
- training opportunities.

The focus groups also provided some other useful information.

- Certainty of outcome relating to registration (and also immigration) was the most quoted requirement of the doctors.
- New Zealand needs to identify what doctors they want and 'then go out and promote this'.
- Doctors are likely to stay longer if they are trying to gain permanent residence, have a family or partner in New Zealand, or have previously worked in New Zealand.
- There is a need for improved checklists so doctors can be assured they have all the right information at the right time.
- Young doctors entering for overseas experience and travel will only stay if they have good reasons, such as access to further vocational training so they can develop their career in New Zealand.

'Mentoring and helping young hospital doctors to develop a career plan is a very useful retention strategy...'

- The vocational pathway is seen as difficult and a barrier, so some younger doctors advised that they do not even try to get through the pathway.
- Uncertainty during the processes and the lack of coordination between the Immigration Department, the Council, and the professional colleges and branch advisory bodies was identified as one of the biggest issues, especially for the groups wanting to settle permanently.

The focus groups also confirmed what we already know.

- A good orientation and induction process, and a friendly New Zealand welcome for the doctor and the family can make settlement a good experience.
- If settlement does not go smoothly for the whole family, then the doctor has to have a really strong 'pull' to remain in New Zealand, such as not being able to return to their home country.
- Language and communication concerns, with one or two notable exceptions, were not issues for the groups spoken to. Culture and different consulting styles need to be considered, but were not seen as a barrier by the sample.
- Differences in approach to medical practice can be addressed by good induction, good supervision, and buddying. For some, a period of observation or shadowing would make practising here easier. Personal and social support at work and in the wider community is important.
- Mentoring and helping young hospital doctors to develop a career plan is a very useful retention strategy; that is, appointing a senior doctor to be responsible for having a discussion with these doctors at 1 month, 3 months, and 6 months about how they are coping and what they need to do and if they wish to stay in New Zealand.

A new publication '*Orientation, induction, and supervision: Best practice guidelines for employers and supervisors of international medical graduates*' will be available from early 2011. This publication provides guidance for employers and supervisors about induction and orientation processes and also sets out the requirements of supervision of IMGs.

The Council would like to thank all the doctors who took part in this research for their time and comments. 🌸

Viewpoint – Professional debates in a period of change

BY PROFESSOR DES GORMAN, EXECUTIVE CHAIR,
HEALTH WORKFORCE NEW ZEALAND

AS IS THE SITUATION FOR ALL NATIONS in the OECD, New Zealand faces a considerable and worsening demand–supply–affordability mismatch in our health service. The response to this mismatch will need to be intelligently informed, innovative, and clinically led if our health system is to be sustainable and fit for purpose.

Some necessary structural changes have been made, such as the formation of a National Health Board (NHB) and Health Workforce New Zealand (HWNZ), along with a quality commission, a capital investment committee, and a shared-services agency. However, these structures in isolation – sensible though they might be – will not deliver the desired result of sustainability and fitness for purpose. A complete revision of the way in which public and private health services are funded and providers are remunerated will probably be necessary for such a level of success.

‘A durable and constructive relationship between HWNZ and the Medical Council of New Zealand is essential to ensure intelligent planning of health services...’

The Minister of Health established HWNZ to consolidate the activity of the quite literally hundreds of agencies who were involved in health workforce planning, and to lead the planning, funding, and development of our workforce across

the sector. As such, HWNZ reports directly to the Minister and oversees the HWNZ Business Unit in the NHB.

A durable and constructive relationship between HWNZ and the Medical Council of New Zealand is essential to ensure intelligent planning of health services against need, create innovative service configurations and models of care, and support reform through clinical leadership. Some joint ventures will need to be led by Council and vice versa. Some have already been formalised and publicised. The reform of general medical practice training and related scopes of practice is an example and the Memorandum of Understanding between the Council, HWNZ and the College should be a template for similar ventures.

We are focusing on a range of initiatives to recruit and retain our medical workforce, including a voluntary bonding scheme for recent medical graduates, an advanced trainee bonding scheme in areas and specialities of need, and a new career guidance scheme.

It is genuinely a time of change, with service reviews, the prospect of shared services for the regulatory authorities, a new Health and Disability Commissioner, and a new Director-General of Health. It is also a time of global austerity and of profound cuts to many countries’ health budgets. This of course means both a time of threat and opportunity.

With this backdrop of change and the challenge of ensuring a sustainable and fit for purpose health system and health workforce, real innovations are needed and some disruption is inevitable. A series of debates are necessary – and in some cases are well overdue.

There are two debates in particular that I would urge medical colleagues to get involved in – one is that of medical registration, the other is the concept of a New Zealand College of Medicine.

The registration question is ultimately one for the Council, but is of great interest to HWNZ and would benefit from cross-sector debate.

The first issue is that of student registration. The aim is to restore the trainee intern to the type of role and function many of us experienced as final-year students, creating an opportunity to enhance the trainee intern year and increase its educational value, while also providing more support to our resident medical officer workforce.

The second issue is a careful consideration of what should be included in provisional registration. This is core to the restoration of the medical apprenticeship; is essential if elements of college training schemes are to be rendered common, vocational training time is to be reduced and medical careers are to be more flexible; and must be underpinned by guarantees of patient safety and quality of care.

‘The question must be what is the purpose of general registration, what is desirable in future, and what would constitute a meaningful transition to vocational integrity?’

The third point is the vexed issue of general registration and just what purpose it serves. It is a bone of contention already in the review of general practitioner (GP) training and scopes of practice. Of the general registrants, 700 or so are working as GPs. It is difficult to maintain an argument for the specialised nature of general medical practice in such a context. Many general registrant GPs are doing a very good job, but they are over-represented in regard to performance issues. We are currently as reliant on general registrants in disciplines such as psychiatry and general medical practice as we are on immigrant doctors, midwives, nurses, and dentists. The degree of this reliance does not substantiate the practice. If general medical practice is the specialised vocation that many of us believe it to be, then how can it be taken up by doctors who are not so trained? The question must be what is the purpose of general registration, what is desirable in future, and what would constitute a meaningful transition to vocational integrity?

The second equally contentious debate is that surrounding a New Zealand College of Medicine. The formation of such a putative college presents the challenge of reforming an Australasian college to meet New Zealand needs; the reality is that the nexus we have with Australia through the Australasian Colleges largely serves an Australian purpose. We have much to learn from how the Canadians manage their relationship with their larger and more prosperous neighbour. It is noteworthy that they have two medical colleges only. The hypothesis here is that might be one too many for us.

A unified New Zealand College could be seen as a natural evolution of the Council of Medical Colleges. It would need to have shared backroom functions to achieve an economy of scale combined with distinct disciplinary academies to manage the training and continuing education of the various medical tribes. Already there are New Zealand Colleges of General Practice and of Public Health. They have the



attraction of being New Zealand-centric, but will always struggle financially and logistically because of their small size. This is not to argue that we have no need for Australasian Colleges and for access to their scholarship and programmes. My guess is that most of us would continue to belong to our current Australasian College as well as a newly formed and aggregated New Zealand version. I have mixed feelings about a New Zealand College, but am certain we need to consider such an option very seriously and very soon.

It is time for change. Indeed, change is unavoidable. The opportunities are many and the need for clinical leadership obvious. The debates highlighted here await us. 🍷

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December 2010