

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

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NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

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CHIEF EXECUTIVE'S FOREWORD

Can we unlock the potential of the house surgeon years?

BY DR JOHN ADAMS, CHAIR, MEDICAL COUNCIL OF NEW ZEALAND



Many Resident Medical Officers (RMOs), particularly those in postgraduate years (PGY1 and PGY2), are dissatisfied with this situation. Not only are they not receiving the teaching to which they are entitled, but they frequently see the clinical and administrative tasks assigned to them as low level and professionally unrewarding. Their frustration is compounded by working in an environment where increasingly sophisticated diagnostic and treatment processes are required for increasingly complex patients, yet RMOs feel they are not learning what they need to know to treat such patients effectively.

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‘Personally, I’m very optimistic about this paper and the possible improvements it identifies that could be made to medical education. After over 20 years of reports and reviews, the paper begins the conversation about not whether, but about what and how change is to be implemented. It is exciting to think that something tangible could emerge that will enhance the quality of medical training in the prevocational years and improve health care for all New Zealanders.’



‘Treating People Well’ Report of the Director-General of Health’s Commission on the Resident Medical Officer Workforce 11 June 2009.

If you have not read the above report, I suggest that you do so. It will help you understand why in mid-May the Council released a discussion paper on the *Prevocational Training Requirements for Doctors in New Zealand*.

The paper reviews prevocational training for doctors. It builds on the work of previous groups charged with exploring medical workforce education and training, including the Medical Training Board and the Commission on the Resident Medical Officer Workforce. It explores the issues and drivers behind the need for change, the purpose and objectives for the first two postgraduate years, recommends key features of a prevocational training framework, and proposes a number of possible options for change.

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but about what and how change is to be implemented. It is exciting to think that something tangible could emerge that will enhance the quality of medical training in the prevocational years and improve health care for all New Zealanders.

There is an opportunity for this to be one of the biggest things to happen in medical training over the next decade.

Our paper has identified a number of issues surrounding prevocational training that we need to look at and find solutions for. They are:

The lack of vertical integration along the continuum of education and training: It is widely accepted that medical education is a continuum with important transitions between university, prevocational training, and vocational training. However, there is currently a lack of integration along this continuum, in part due to the number of organisations involved in medical education and training, each of which, before the establishment of Health Workforce New Zealand (HWNZ), have not had the sole mandate to systematically coordinate programmes.



Balancing increasing service demand with increasing training needs: There are inherent tensions between service delivery and the training needs of doctors that are placing the traditional apprenticeship model under pressure. Rather than gaining valuable experience in diagnostic and treatment processes, many doctors have reportedly felt that they were regarded as ‘units of labour’ to be deployed to cover service need including low-level administrative tasks.

A hiatus in training: Despite the fact that most doctors do not enter vocational training until they have completed at least two postgraduate years, there is no regulated requirement for formal training in place for doctors during their second postgraduate year.

More emphasis needed on obtaining broad-based core competencies: Much of our population is located in regional centres and is disproportionately increasing in age, leading to a growing proportion of people with long-term, age-related conditions. Doctors in these regions must provide services across a broad range of accident and illness and require core general competencies in order to do so.

Training too hospital-focused: With the current and projected increase in the incidence of age-related and chronic conditions, a greater share of medical services will need to be provided in community settings with a focus on prevention and long-term management.

Locums and safety concerns: There is evidence that the use of PGY2 locums has been increasing over the past 10 years and continues to rise. In this situation, the doctor could have limited or no experience in the area of medicine in which they undertake the locum, and supervision could be from a distance. Both of these issues raise concerns over the safety and quality of services PGY2 locums are providing and the training they receive.

Funding and accountability: There is currently no accountability mechanism, such as key performance indicators, linked to the funding provided for prevocational training. It is therefore difficult to determine to what extent funding is actually invested in training and to quantify its value.

We’ve put forward four options as possible solutions for these issues. Although we do not have a preferred option at this time, the status quo for medical education is not an option.

The Council has proposed a set of core features to be introduced into the prevocational framework. These include:

- extending the length of runs from 3 to 4 months
- certain specified runs with consideration also being given to compulsory runs in community care (general practice), emergency medicine, and psychiatry
- introducing a revised curriculum adapted from the *Australian Curriculum Framework for Junior Doctors*. This curriculum, where doctors must demonstrate competence in the domains of clinical care, communication, and professionalism, will overarch **all** runs.

Once we’ve received and considered the feedback, we will determine the next steps in this review. Our aim is to improve the training experience for junior doctors and ensure they gain the core general competencies to practise across the breadth of medical practice.

Doctors should be able to demonstrate clinical skills across a range of competencies specified by the Council through an improved model of ‘supervised learning’, before gaining registration in a general scope of practice and entering vocational training.

I would urge you to share your views with us about the changes we’re proposing to training for PGY1 and PGY2 doctors.

The **discussion document** can be read online. Submissions on it can also be made online at www.mcnz.org.nz and close on **22 July 2011**. 📧

Viewpoint – Introducing the Health Quality & Safety Commission

BY PROFESSOR ALAN MERRY



PROFESSOR ALAN MERRY chairs the Health Quality & Safety Commission. He is a practising cardiac anaesthetist and chronic pain specialist, and also chairs the Quality and Safety Committee of the World Federation of Societies of Anaesthesiologists.

In New Zealand we are accustomed to an excellent health system by international standards.

On the other hand, there are still important differences in the care received by different groups within the population and in different parts of the country, and this is reflected in differences in health outcomes.

The cost of health care is increasing, partly because of changes in the demographics of our population and partly because of ongoing advances in medications and technology. Recent economic events have added to the challenge of maintaining our position and providing safe and effective health care to all who need it.

Even in very well-funded systems (for example, in the USA), far too many patients are harmed through mistakes that ought to be preventable. Accurate estimates of the extent of this harm are difficult to obtain, but a study in New Zealand in 2002 suggested that 12.9 percent of our hospital admissions were at that time associated with an adverse event (although many of these events were relatively minor).¹

For comparison, reports from Australia and Britain suggest rates of 16.6 percent² and 10.8 percent³ respectively.⁴ The differences probably reflect differences in the methods used, and these figures should be interpreted as illustrative rather than accurate. About half of these adverse events are thought to be preventable.

The Commission was established in November 2010 to lead quality and safety improvements in the health sector. Its establishment was an important part of the Government's response to maintaining and improving the standard of health care for all New Zealanders. Our responsibilities include both public and private sectors, and disability services as well as health care.

We inherited several excellent programmes started by the former Quality Improvement Committee. These include the annual serious and sentinel events reporting, infection prevention and control, and safe medication management. It is very important that the return on money invested in good initiatives is realised, and that good projects, once started, are carried through to deliver on their potential – so we have placed considerable emphasis on these existing programmes.

At the same time, we have undertaken a careful review of priorities and are working on important new initiatives which we expect to make a measurable and tangible difference to the quality and safety of our services.

It is very important that the different groups now operating in the governance of our health and disability services work together. Therefore, with the National Health Board, we have agreed a common overarching aim, based on the Institute of Healthcare Improvement's Triple Aim and modified for New Zealand.

The New Zealand Triple Aim is the simultaneous pursuit of:

- improved quality, safety, and experience of care
- improved health and equity for all populations
- best value from public health system resource.

1 Davis P, Lay-Yee R, Briant R, Ali W, Scott A, Schug S. Adverse events in New Zealand public hospitals 1: occurrence and impact. *N Z Med J* 2002;115:U271.

2 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton J. The quality in Australian health care study. *Med J Aust* 1995;163:458-71.

3 Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. *Br Med J* 2001;322:517-19.

4 The differences in rates probably reflect slight differences in the methods used in each study.

To this end, our priorities are:

- supporting consumer engagement and participation
- working with providers to support improvement and innovation
- infection prevention and control
- medication safety
- evaluation and reporting on the quality and safety of the system
- falls prevention
- supporting the work of the four mortality review committees, now operating under the Commission's auspices
- continuing to respond to events reported to the Commission.

Our emphasis will be on quality improvement rather than quality assurance.

Medication errors are an ongoing and potentially serious cause of patient harm. The Commission is working closely with the National Health Board, the National Health IT Board and others to implement ambitious changes to the way medications are prescribed, dispensed and monitored in our hospitals and in primary care.

The ultimate aim is a series of well-integrated and functional electronic systems for prescribing, reconciling, and tracking medications. In this context, computerisation in itself does little, but rather facilitates good processes and makes them more efficient.



‘Actions speak louder than words, and much can be done to facilitate or impede good projects through very simple aspects of individual behaviour...’

The first steps, therefore, are to ensure that the simple physical processes leading to safe medication practices are in place. In some areas, paper-based systems may serve for many years, while others are already moving rapidly to electronic systems. Typically, progress depends on scale and on funds.

This year we are asking all district health boards (DHBs) to implement a standardised, national medication chart for adult patients in hospitals. We expect this to be in place in most public hospitals within 7 or 8 months. It is salutary to note that Australia has had a standardised medication chart in its hospitals for some time – ours is long overdue.

Standardisation is a key principle of quality improvement, well proven in aviation, for example. The standardised medication chart project has been underway in New Zealand for several years, and shows our intention to coordinate and accelerate existing activities.

We are also asking the DHBs to introduce a formal medicine reconciliation process to make sure patient medicines are checked at critical handover times (notably on admission to, and discharge from, hospital). Mistakes at these junctures are common, often harmful, and occasionally lethal.

Again, the aim is to get the physical processes working, and bring in the efficiencies of electronic systems soon thereafter. It is worth noting though, that the core requirement is for a doctor and/or a pharmacist (or perhaps both, together, in complex cases) to review each patient's medications and make sure they are correctly prescribed.

When medications are changed in hospital, GPs need to be told that these changes are intentional, and why they have been made. Again, the end game of this project will be electronic, but the first steps are about engaging clinicians and managers in the primary notion that tolerance of medication errors is not acceptable.



That does not imply a need for blame – rather this is a classic example of the need for system change to improve outcomes. The aim here is to reduce harm and increase the effectiveness of our health care services. In the end, it is about making sure that our clinicians do what needs to be done. This is about having a strong quality and safety culture.

Infection is a major problem in health care. Hand washing has improved with the initiatives begun by the World Health Organization and adopted by New Zealand and most other countries in recent years, but audits still show that compliance with this basic safe practice is often unacceptably poor.

The challenge now is to maintain momentum. We do not want good initiatives to wither, or to end up as futile tick box processes: rather we want change that is effective and embedded. Hand washing will be part of a wider programme on infection, which will also address central line infections and surgical site infections.

Similarly, we will continue to promote the World Health Organization Safe Surgical Checklist. International evidence provides compelling support for the use of well-designed checklists in surgery⁵ because they help surgical teams avoid mistakes and function more effectively as teams in the operating theatre.⁶ The introduction of the surgical checklist to New Zealand hospitals has been another example of successful system change, but again, its use needs to continue in an effective manner. A nurse reading a list does not constitute using the checklist – everyone needs to engage if the potential of this approach is to be achieved.

5 Haynes, A.B; Weiser, T.G; Berry, W.R. et al 2009. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine* 360; 5 491-99.

6 Birkmeyer, J.D. 2010. Strategies for Improving Surgical Quality – Checklists and Beyond. *New England Journal of Medicine* 363; 20 1963-65.

Health care variation reporting has been shown internationally to be a powerful tool in highlighting the use of ineffective or inappropriate interventions, and the under-use of effective interventions. An example in New Zealand is the still-significant variation in the use of statins, aspirin, and beta blockers for patients and consumers at risk from coronary artery disease. In 2011/12 the Commission will publish its first health care variation report. The report is expected to identify opportunities for improvement in practice through interventions in different parts of the country, and between different population groups (for example, by age, sex, and ethnicity).

We can't achieve quality and safety improvements on our own. We need the support and active involvement of everyone in health care, particularly those with senior roles. Actions speak louder than words, and much can be done to facilitate or impede good projects through very simple aspects of individual behaviour, particularly on the part of leaders. Senior doctors should consider the widespread impact of simple things like taking part in the checklist, and hand washing before examining patients. Actions of this type make it clear that safety and quality really matter.

The Council plays a particularly important role in health care through its education, training and competency programmes, and we look forward to working closely with the Council to maintain and improve the excellence of service that New Zealanders expect.

To find out more about the Commission and our work programmes, visit www.hqsc.govt.nz. You can register on the site to receive regular updates about quality and safety news and issues. 📧

OUR PEOPLE

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Viewpoint – Supportive but not restrictive; What medical students want out of prevocational training

BY OLIVER HANSBY, PRESIDENT, NEW ZEALAND MEDICAL STUDENTS ASSOCIATION. EMAIL president@nzmsa.org.nz

LIKE GOOD PARENTING, the key to improving prevocational training in New Zealand is striking the balance between providing enough protection and support, without becoming overbearing and restrictive. The Medical Council of New Zealand's (Council) review of *Prevocational Training Requirements for Doctors in New Zealand* provides an excellent overview of some of the longstanding shortfalls of prevocational training in New Zealand, and offers some potential solutions for these failings. The challenge now is to find a solution that enhances protection and support without becoming overbearing.



As the peak representative body for medical students in New Zealand, the New Zealand Medical Students' Association (NZMSA) has long taken an interest in the good and bad features of the current prevocational years. As discussed in the Council's review, the prevocational years have been plagued by a lack of education and an overemphasis on service delivery. There have also been concerns surrounding competency and the hospital-centric nature of the prevocational years, particularly given that New Zealand is projected to need more and more doctors practising in community settings.

Despite these flaws, New Zealand's current prevocational training requirements do have some positive components. The most obvious positive point linked to the current prevocational requirements is that general registration can be earned in 1 year; a period of time that is the same in both New Zealand and Australia. As some medical graduates would arguably be attracted to a location that offers the shortest course to general registration, the fact that New Zealand and Australia share a common period of time for general registration means that there is no added incentive for

New Zealand graduates to undertake prevocational training in Australia.

In addition to the benefits associated with a 1-year general registration period, the current prevocational years also have the advantage of a relatively flexible post graduate year 2 (PGY2). While some might cite the current PGY2 as a wasted year, a number of medical students relish the idea of the flexibility that is inherent to the PGY2 year. After 6 years of rigidly prescribed study at medical school, and with a decade of structured vocational training ahead, many medical students see a slightly flexible PGY2 year as a chance to explore and experiment before committing to a training scheme. The PGY2 year provides a valuable silo of flexibility that medical students want, and often need.

Regardless of the positives and negatives associated with the current prevocational training requirements in New Zealand, the Council's review made it clear that the status quo is not acceptable and cannot continue. The review outlined several possible solutions for addressing the current problems in New Zealand's prevocational training requirements. First and foremost, embodied within the review is an underlying commitment to enhance the level of training and education in the prevocational years. NZMSA sees this commitment to education and training as an integral component in solving some of the problems associated with the current prevocational years.

In addition to the Council's overall commitment to improvements in education and training, the review also posed a range of possible structural changes that aim to improve the prevocational years. At the heart of these proposed changes is an extension to the length of clinical placements, from 3 months to 4 months. The review



cites that the rationale for this extension is based on a recommendation in an 'evaluation of the UK Foundation Programme'. The cited evaluation, *Foundation for Excellence*, bases its recommendation on the fact that 'Ninety percent of Foundation School rotations comprise of three placements of 4 months' and that 'there is no support for placements that are shorter'.⁷ NZMSA is concerned that the Council is basing an extension to the length of clinical placements in New Zealand purely on the opinion the UK, where 4 month placements are the status quo.

Putting aside concerns about the rationale of a 4 month clinical placement, of the range of options articulated in the review, the ones that are most preferable to the NZMSA are those that encompass changes that increase support and deal with the issue of competency, without being overbearing and significantly compromising the flexibility associated with PGY2 and the length of New Zealand's 1 year general registration requirement.

The option outlined in the review that most suitably meets these terms is Option one, which requires 4 month runs in surgery, medicine and either community care or emergency medicine for general registration. The advantages that make Option one preferable is that it strikes a balance between improving competency by including either a community care or an emergency medicine run, while not imposing additional

time for general registration beyond 1 year; a factor that will prevent a number of new graduates moving to Australia to seek general registration.

Option three outlined by the Council in the review also involves a 12 month general registration period, however this general registration comes with a caveat. The caveat is that the general registration is actually partial registration and does not apply to practice in the areas of general practice or emergency medicine, unless training runs are undertaken in these areas. This option is restrictive and may add another barrier to doctors wanting to practise in community care.

The two other options described in the Council's review (Options two and four) include structural changes to prevocational training that lead to an extension in the time required to earn general registration. This extension will likely significantly restrict the flexibility of PGY2 and may also encourage new graduates to seek a shorter 1 year general registration in Australia.

Overall, NZMSA believes that the current prevocational years need to be improved, with greater support for prevocational trainees. The embodying theme of the Council's review of enhancing support through education and training is a vital step towards making this improvement. Regardless of how New Zealand's prevocational training requirements are restructured, it is important that the focus remains on support and protection, without unduly restricting prevocational trainees. 🌱

⁷ Medical Education England. *Foundations for Excellence: An Evaluation of the Foundation Programme*. Oxford: Medical Education England; 2010

Reflections on the Canterbury earthquakes

BY PROFESSOR RICHARD SAINSBURY, UNIVERSITY OF OTAGO, CHRISTCHURCH AND PROFESSOR MIKE ARDAGH, EMERGENCY PHYSICIAN, UNIVERSITY OF OTAGO, CHRISTCHURCH

AT 4.35AM on 4 September 2010, the tranquillity of a Canterbury spring morning was shattered by an earthquake measuring 7.1 on the Richter scale, centred about 30 kilometres from the city of Christchurch.

There were no direct fatalities as a result of this earthquake but there was extensive damage and many injuries. There was also a well-documented increase of cases of ischaemic heart disease. The region was rocked by aftershocks in the ensuing months including a 6.3 magnitude earthquake on 22 February 2011, which had devastating results including a death toll of 182. This created major problems for health services.

The orthopaedic service alone treated 130 new fracture cases, 31 of whom were frail older people with hip fractures. Extensive damage to rest homes meant that 500 residents had to be relocated to other centres at short notice. Despite extreme pressure on health services, the staff appeared to handle the situation well. A group called Research into the Health Impact of Seismic Events (RHISE) chaired by Emergency Medicine specialist Professor Mike Ardagh has been established to coordinate the large number of research projects that will evaluate the health impacts of the earthquakes.

Natural disasters such as these inevitably cause stress for those who experience them and health professionals are no exception. Shortly after the first earthquake, an advertising campaign featuring prominent sportspeople was launched with the slogan, *'Look after others, look after yourself'*. The slogan was apt and the first part could be seen in the hours immediately after the February quake as people rallied to help others and the standard of driving was uncharacteristically courteous despite people being in a rush to return to their homes to assess damage. Of equal importance is the need for people to look after themselves and this applies to health professionals, many of whom had to work huge hours under immense pressure.

An emergency such as the earthquake creates exceptional circumstances that need immediate solution. The case of the

man who needed a double leg amputation, using tradesman's tools in cramped and dangerous circumstances, to save his life was a much publicised example.

There were countless others.

Clearly a health professional confronted with a life-threatening situation is obliged to render whatever assistance they can, even if this means acting beyond their usual scope of experience. While desperate problems may require desperate solutions, the basic standards of care and ethical responsibilities are unchanged.

Beyond the heroic actions demanded of some, there are many health professionals who contributed, and a proportion harbour a sense that their contribution was somehow deficient – they didn't do enough, or might have done more but prioritised their own or their family's needs. Others feel the guilt of not being there at all, and all Christchurch health professionals suffer the anxieties common to all locals related to damage to homes, disrupted lives, recurrent aftershocks, and the recognition that recovery will take a long time.

'While desperate problems may require desperate solutions, the basic standards of care and ethical responsibilities are unchanged.'

At times like these, we need to be vigilant about recognising signs of stress and illness in ourselves and our colleagues and using appropriate care and support services. The temptation to self-prescribe or to write a short-term script for anxiolytics or antidepressants to a colleague who is not your patient should be resisted.

It is no exaggeration to say that life is not the same in Canterbury since the earthquakes. At the same time, benefits may well arise from the crisis. We will be challenged to consider the ways in which health care is delivered. We have been provided with a rapid spur to evaluate initiatives for increased community care, including services that have traditionally been provided in hospitals. All this should be carefully evaluated and we should be mindful of the need to look after both ourselves and our colleagues in these testing times. 🙏

Ethics 101

Do you know when it's inappropriate to accept a gift from a patient? What do you do if you hear that one of your colleagues is limiting patients to one medical complaint per visit? Can you refuse to accept a new patient if their medical history is complex? 🗣️

When faced with these types of dilemmas, doctors often contact the Council for guidance. The details of each individual situation tend to be unique and the advice to one doctor may not be the same as to another doctor in a similar situation.

To encourage dialogue on these issues, the Council has introduced the Ethics 101 column – inspired by a column published by the College of Physicians and Surgeons of Alberta. In each issue this column will outline an ethical situation and we'll ask for opinions from the profession. A selection of responses providing various viewpoints will be published in the following issue.

There will be no 'right' or 'wrong' answers – but rather we aim to hold a thoughtful discussion about the pros and cons of various approaches. This approach will allow doctors to benefit from the wisdom of their colleagues, and will also create interest amongst the profession about practical ethical issues.

WHAT WOULD YOU DO?

You have been involved for several years in the care of an elderly patient with a chronic illness. Following a recent hospitalisation for pneumonia, this patient gives you an envelope that she says contains a small thank you for the care you provided. You open the envelope to find a \$200 gift certificate for a local tailor who you know does excellent work. What would you do in this situation?

Email your views to Michael Thorn, Senior Policy Analyst, at mthorn@mcnz.org.nz (use the subject line 'Ethics 101'). If you have ideas for topics for future columns, please feel free to send them to us as well. 🗣️

RESPONSES TO OUR PREVIOUS COLUMN

Our last column asked what you would do if:

The district health board (DHB) has proposed to close your department. You disagree with the rationale for the decision, and don't believe that it is in the interests of your community's health and safety. You have tried to reason with DHB management, but feel that they did not listen to your concerns. The debate has become very heated, with people writing to the local papers, elected officials grandstanding, and DHB management issuing media releases. You feel that much of the information being circulated in public is misleading or wrong. Some of your colleagues are quite angry about the situation, and one has shown you a letter he sent anonymously to a television programme in which he claims that closing the department will cost 'seven lives a year'. While you agree with his views on closing the department, you think that this particular claim is exaggerated and based on an unscientific analysis of the facts.

You feel a duty to the community to keep the department open, and working through official channels has not got you anywhere. Now a television journalist is on the phone. She has received the anonymous letter from your colleague and tells you that she hopes to run a story about it and the department's closure as the lead item on that night's news programme. You get the impression that she only thinks the story is newsworthy because of your colleague's claim about the closure costing 'seven lives a year'. She asks you for your comments.

You open the envelope to find a \$200 gift certificate.

What would you do?



We received thought-provoking responses to this question from three correspondents.

Dr Damian Mosquera, a general and vascular surgeon, said:

I would probably reply 'no comment'. However, in general I think we withhold too much from the general public. We are supposedly advocates for the patient and are continually reminded about our duty regarding full and open disclosure.

If the facts in this case are incorrect, they need to be corrected. In general the only reason that we are reluctant to engage with the press is that we are concerned about the spin and editorial cuts that may be introduced on top of any factual comments. The public pays for the health service and has a right to information on any aspect of its organisation. Perhaps if there was more routine engagement with the public through journalists, there would be less hype about the stories that do make it to press.

An Auckland GP stated:

I would advise the journalist that I am contractually bound not to make independent public comment by my DHB employer. Nonetheless I have strong opinions on the matter and believe the action of the DHB in closing the department is short-sighted and not in the best interest of the taxpayer or patients. I do not agree to be quoted on this, but suggest that the journalist approach the DHB on the matter of contractual 'gagging' of clinicians. The journalist might like to discuss with the DHB, and subsequently print their response, how the Human Rights Commission might view such a 'gagging' order, with a view to the DHB agreeing to a more open discussion of the matter in the public domain with clinician input.

A doctor working in a DHB stated:

My DHB has produced a report that proposes closing and contracting out a key service so your question is not hypothetical. We are living the experience. The DHB proposal is ill-informed, impulsive and injudicious. A key lesson has been that it is impossible to develop a mental plan to deal with DHB staff who claim to consult but do not, and who ride rough-shod over patient and staff input and interests.

Realising that a small number of concerned staff members would not affect the proposal, I elected to involve my union whose officers have proved to be well informed, sanguine, and judicious. The well-prepared, coherent, and firm approach of the union officers has forced the DHB to reconsider and withdraw its plan and apologise. This support has been effective where staff input was being overruled, and very reassuring to me.

Seeking media support would drive the debate in the opposite direction to effective progress as most media stories are selected for impact rather than balance. My one involvement with a journalist was to release public information about services offered by the department and even then the printed story got it wrong. My colleagues and I have no skillset for media encounters, so I would leave any media contact to experts in the professional organisations that represent me.

Many thanks to these doctors for sharing their opinions with us.

New publications

Best practice guidelines for employers and supervisors of international medical graduates

The Council's new **handbook** for employers and supervisors can be read online. The booklet sets out the roles and responsibilities of international medical graduates (IMGs) coming to work in New Zealand, and their employers and supervisors.

Medical cultures around the world are different. Good orientation, induction, and supervision will help IMGs new to New Zealand to understand and learn about our medical system and culture.

IMGs who are new to New Zealand will need your help to get used to our systems, processes, and culture. The better the orientation, induction, and supervision processes, the sooner the IMG will be able to contribute effectively to your service.

This booklet will help you to understand Council's requirements for supervision of IMGs. It includes information on:

- the role of a supervisor
- offsite supervision
- what to include when submitting a proposed supervision plan to Council for consideration.

The handbook may be downloaded at the link above or if you would like a hard copy, please email info@mcnz.org.nz.

Recertification and continuing professional development

The Council's has produced a new booklet on *Recertification and continuing professional development*. Setting out the Council's expectations, the booklet provides guidance on recertification and continuing professional development (CPD), as well as the responsibilities to undertake CPD.

CPD is involvement in clinical audit, peer review, and continuing medical education, aimed at ensuring that a doctor is competent to practise medicine. It is also intended to foster a culture of peer support and lifelong learning.

Recertification is used to ensure doctors are competent to practise within the scope in which they are registered. Recertification helps provide assurance to the public and patients that practising doctors are competent and safe to practise.

The handbook may be downloaded at the link above or if you would like a hard copy, please email info@mcnz.org.nz



Council statements

In recent years, the Council has produced over 30 statements on topics such as:

- information, choice of treatment, and informed consent
- best practices when providing care to Māori patients and their whānau
- unprofessional behaviour and the health care team
- cosmetic procedures
- ending a doctor-patient relationship.

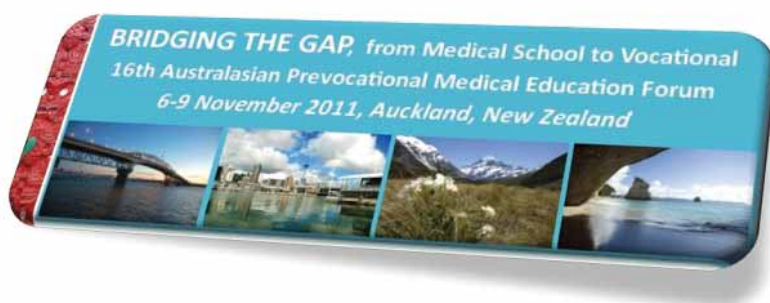
As new standards and guidelines are produced, or others are updated, we will send them to you automatically with *Medical Council News*. All statements can be **downloaded** from our website, www.mcnz.org.nz » resources » standards and guidelines. 📎

Prevocational Medical Education Forum

The Council is delighted to be hosting the 16th Prevocational Medical Education Forum in Auckland from 6 to 9 November 2011, particularly as this is the first time it has been held in New Zealand.

The theme of this year's Forum is 'Bridging the Gap: From Medical School to Vocational'. Sub-themes at the Forum are:

- Providing the Pillars: the framework for internship, including the purpose of internship, appropriate standards and accreditation of these, and learning and assessment processes
- Supporting the Journey: training and supporting the teachers and supervisors, supporting new graduates, addressing the tension between service needs and training needs, resolving sentinel events, and achieving a balance between health, wellbeing, and work
- Achieving Integration: achieving excellence, ensuring cultural competence, promoting ethical practice, enhancing professionalism, developing tacit learning, fostering future professional leadership, encouraging lifelong career planning, and addressing health inequalities.



This annual event brings together a wide range of international and national speakers, medical education officers, clinical trainers and educators, managers, researchers, and academics to join with the prevocational doctors in debate and discussion.

Many issues face doctors as they move from medical school to a vocation of their choosing, including finding a balance between developing clinical skills and service, lifelong learning and the demands on their time. Major health reforms still working their way through the sector also pose their own challenges.

The Forum is your opportunity to meet, debate, engage, and plot the way forward as the impact of rapid change both in Australia and New Zealand continues.

The Council gratefully acknowledges and draws upon all that has gone before in previous forums since its inception in 1995 by the Postgraduate Medical Education Councils and aligned professional bodies.


More information about the Forum can be found at www.prevocforum.org.nz 📎

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](#)
- 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 told us their new addresses.

If you change your address, please let us know your new address within a month. You can change your address [online](#).

The following doctors will be removed from the medical register unless we receive their new addresses:

Dr Natalie Claire Blane
Dr Noel John Brown
Dr Roderick William Grant Campbell
Dr Laura Elizabeth Carlin
Dr Peretiso Faletoes
Dr Rex Noel Frye
Dr Andrew Peter Grant
Dr Rachel Harrison
Dr Christopher Yung Yoo Leow
Dr Ian Lachlan McLean
Dr Celine Mary Murphy

If you know how to contact any of these doctors, please email apc@mcnz.org.nz or phone 0800 286 801 ext 785. 

Vocational practice assessments

In the December 2010 issue of *Medical Council News*, we outlined our registration process for doctors applying for registration in a vocational scope of practice. We explained that doctors who hold an overseas postgraduate qualification (but not an approved New Zealand or Australian fellowship, diploma or certificate) can apply for a vocational scope so that they can be recognised by the Council as a specialist.

WHAT IS THE VOCATIONAL PRACTICE ASSESSMENT?

In late 2006, Council introduced the vocational practice assessment (VPA) as a tool to assess the competence of doctors who had been granted a provisional vocational scope of practice based on their overseas qualifications, training and experience being assessed "as satisfactory as" the New Zealand or Australian fellowship, diploma or certificate qualification.

The VPA process is intended to assess competence prior to the Council deciding whether to grant these doctors a change of scope from provisional vocational to vocational registration. It is our preferred tool for assessing the competence of the doctor, as it enables us to determine whether the doctor is:

- practising at the level of a New Zealand-trained doctor holding the prescribed fellowship, diploma or certificate qualification;
- practising at the level of a doctor registered in the same vocational scope; and
- capable of independent and unsupervised practice across the broad vocational scope of practice.

WHO UNDERTAKES THE ASSESSMENT?

The VPA is generally a 1 day assessment with two assessors who act on the Council's behalf, observing the doctor's practice and interaction at the doctor's workplace – giving them an opportunity to demonstrate their competence.

The VPA assessors are selected using a number of criteria that include:

- which vocational scope of practice the assessor is registered in
- good standing with the appropriate medical college
- experience in public and/or private practice, or tertiary and/or rural settings
- experience in a subspecialised area of medicine.

TOOLS OF THE VPA

The VPA typically includes the following tools:

- opening and closing interview
- observation of procedures (where appropriate)
- observation of interactions with patients in an outpatient setting and during a ward round
- a review of 20 consecutive patient records from their caseload
- case-based oral assessment, based on the knowledge and competencies required for the specific scope of practice, records selected for records review, and observation of the doctor with patients
- an interview with colleagues
- peer ratings from medical and non-medical colleagues (completed before the day of assessment).

Sometimes these tools may be modified depending on which vocational scope the doctor is being assessed in.

WHO NEEDS A VPA?

A common question from doctors is whether they will be required to undergo a VPA.

We apply a VPA to doctors from overseas, whom we deem eligible for provisional vocational registration, when we believe that further assessment (in addition to working under supervision for a period) of the doctor's competence is required. The VPA is usually required when all or any of the following applies:

- the doctor has not completed any clinical examinations (for example assessment and observation of the doctor undertaking clinical tasks at their place of employment, or with role playing patients)

- the doctor has not completed any external examinations (for example national or regional level examinations)
- the doctor has not completed any exit or final examinations at the conclusion of their postgraduate training
- the doctor has not completed an objective and independent accredited postgraduate training programme
- competence issues have been identified related to qualifications, training, and experience, or registration and practising certificate policies.

TIMELINE OF THE PROCESS

Before the VPA

Three months before the end of the supervised period, Council staff will contact the doctor to arrange the date of the VPA, and discuss assessors' and the doctor's availability.

Once a date is agreed, the doctor will be sent the Terms of Reference (TOR) outlining what will happen on the day of the VPA. The TOR set out who the assessors will be and where the VPA will take place. The doctor is given the opportunity to comment on the TOR and raise any concerns. Until the TOR are signed off by the doctor, we are unable to move forward with the VPA.

After the VPA

Once the VPA has been completed, the assessors send their report to Council staff with a recommendation that the doctor's practice is either *satisfactory* or *not satisfactory*.

If the VPA recommendation is *satisfactory*, staff will make a decision on the report under delegation. At the same time, staff will decide whether to grant a vocational scope. They will take into account all information before them, including supervision reports, medical college advice, application, CV, referee reports, etc.

If the VPA recommendation is *not satisfactory*, the VPA report (along with the additional information outlined above) will be taken to a full Council meeting for consideration. Council will usually consider at the same time whether the doctor should be granted a vocational scope. There is no typical outcome from a full Council meeting, as each case is considered on its own merits.

WHO TO CONTACT FOR MORE INFORMATION

Pauline-Jean Luyten, Registration Team Leader (Vocational) at pluyten@mcnz.org.nz, 0800 286 201 extn 811; or

Chrissy Takai, Vocational Registration Coordinator at ctakai@mcnz.org.nz, 0800 286 801 extn 761. 



Reflections on a supervisor training day

BY DR GREVILLE WOOD, CLINICAL DIRECTOR, RURAL ACADEMIC
GENERAL PRACTICE, WEST COAST DISTRICT HEALTH BOARD



In November 2010, I attended an international medical graduate (IMG) supervisor training day in Christchurch.

The city was still reeling from the September earthquake and Cathedral Square was eerily quiet (our venue was just off the square). It was a sunny day and the venue was great. To my great surprise Shelley Louw, a class mate from the University of Cape Town was on the course and we had a great day catching up on the last 25 years since our graduation. Shelley's practice had been badly damaged in the September 2010 quake.

Catching up with former colleagues and meeting new ones is always a highlight of these meetings. The round-the-room introductions are always great. We are such a diverse range of people and I find it inspiring hearing of the great and innovative work being done in various practices.

As usual these sessions give you a chance to leave the day-to-day work behind and focus on a task that is critical to your being a general practitioner (GP) on the West Coast. The Coast has just three New Zealand-trained GPs, which means we are constantly supervising international medical graduates to enable us to have a workforce to serve our community. I was surprised that many urban areas were having similar issue. I was particularly impressed with the group of delegates from East Tamaki, who have a particular passion for supporting IMGs as they settle into the country. This

group of practitioners have gone out of their way to create an environment in the practice that supports IMGs as they learn our system.

The learning objectives for the day had been formulated taking in to account feedback from earlier training sessions and they were:

- To be conversant with, and able to demonstrate, best-practice supervision, including maps and models of supervision, supervision tools, giving feedback, dealing with difficult and poorly performing clinicians
- To deal with cultural differences and different approaches to practising medicine
- To be conversant with, and able to demonstrate awareness of, Council's processes and requirements for regulatory supervisors of IMGs.

The day was expertly facilitated, the material discussed and role plays were well thought through and all were relevant and educational. The Medical Council staff were very helpful. It was good to dispel the mythology and hear from the Council their vision for the future.

In essence, the Council is seeking supported, structured, and self-regulating environments into which doctors new to New Zealand can be placed as they find their feet in our complex health care environment. The role is very closely aligned to supporting a GP registrar in the practice in their GPEP 1 year. The Council is committed to this process and will continue to support those who choose to be involved in supervision. There are requirements that need to be fulfilled but these are some commonsense measures:

- a good orientation process – in the practice and in the community
- regular times to meet and discuss issues
- proximity on a day-to-day basis to discuss clinical and administrative issues
- formal reporting back to the Council, which also is feedback to the IMG.

By the end of the day, we had renewed friendships, started new ones and realised that supervision is not as onerous as it is made out to be.

The next IMG supervision training days are scheduled for:

29 September – Dunedin

6 October – Auckland

If you would like to know more about these days, please email Laura Lumley at llumley@mcnz.org.nz or phone 0800 286 801 extn 991. 📞



A message to our Christchurch colleagues on Monday, 13 June 2011



Dear colleagues

It was with considerable concern and sadness that I learnt this afternoon of the magnitude 5.5 and 6.0 earthquakes that rocked Christchurch earlier today.

In September and February, the profession collectively rose to

the challenges that Christchurch posed. In the face of danger to themselves, many doctors administered care and comfort to patients in situations of extreme danger they would never have thought possible. More often than not you put the casualties of February 22, ahead of yourselves or your families.

Too often, it is easier to focus on the negative and ignore the positives, but what you have all done for your patients in the face of hardship and adversity, represents the very best traditions of the medical profession and why we chose to become doctors.

Ironically, in this issue of *Medical Council News*, Dick Sainsbury, a Christchurch Council member and

Professor Mike Ardagh both reflect on how life has changed since the February 22 earthquake.

Some of you will be naturally anxious and no doubt fearful of the future. I would urge you to seek the support of colleagues or the support of the Medical Protection Society who are offering free access to psychological support and can be contacted on 0800 225 5677.

I also wanted you to know that my thoughts, and those of all Council members and staff are with you and your families at this time.

Kia kaha

Dr John Adams

Chair

Medical Council of New Zealand



Contact details

Medical Council of New Zealand
Level 13
139 Willis St
PO Box 11649
Manners Street
Wellington 6142

PHONE 0064 4 384 7635
FREEPHONE 0800 286 801
FAX 0064 4 385 8902
EMAIL mcnz@mcnz.org.nz
WEBSITE www.mcnz.org.nz

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