Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group X [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
In principle, [redacted] agrees with the use of performance and outcome data, multi-source feedback and external peer review to identify their professional development needs. Currently there are no systems in place for this within our College so we respectfully request some flexibility in the timelines on achieving this. Currently this process is hospital-led so this would require significant system and culture change to implement.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

In principle [redacted] grees with vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs. As this is a significant shift for our College which would require organisational restructuring, we request support and a suitable transition time. When discussed at committee level, some practical difficulties were raised with regard to the DHB/employer responsibilities.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

[redacted] agrees that medical colleges should define knowledge requirements for their vocational scope(s) of practice and be responsible for incorporating these into their recertification programs. [redacted] currently has a document detailing attributes of a Fellow [redacted] but this document is generic so it would need significant updating. Additionally, we have a number of sub-specialities with very different skill sets so defining the knowledge requirements would be quite a body of work for our College so we request a suitable transition time to allow for development of these scopes of practice.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[redacted] agrees with the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification and is something our College already does. We already have a tool for this. Our feedback would be that this should remain optional as it is an expensive exercise for the doctor. [redacted] offers the following points for consideration

- Requiring the College's to assume a policing role would result in reduced collegiality which is critical for the function of our College.
- Success of the current practice visits program is due to its voluntary nature and the fact that reviewers come as "friends not foes".
- If this process were to progress to a mandatory practice, where would responsibility lie within a mandatory practice review system i.e. who would own the report, who would initiate the follow-

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

through and who is responsible for the outcome (the doctor or the employer?).

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Additional support is a very broad term. It would depend on the type of support, how serious the performance issues are, whether the performance issues relate to clinical medico-legal issues. Currently our college is not resourced to do this task. The relationship we have with our Fellows is a voluntary one so it may be difficult for our College to perform this function effectively.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

[redacted] recommends caution if the Medical Council is considering mandating certain activities based on age. We feel strongly that ageism should be avoided. There is no evidence that poor outcomes are a result of age. Often poor outcomes are associated with lack of experience which can be more prominent in the case of the sole practitioner, those from rural and remote areas, or those from culturally and linguistically diverse backgrounds (e.g. including but not limited to specialist international medical graduates). The ageing doctor should be dealt with fairly and safely. We believe that there should be ways to use their skills positively. We also feel that there should be an awareness of implications of staff shortages. The Medical Council should consider rurality and language barriers of greater concern than age.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

[redacted] is mindful of the need for continuous quality improvement but the collection and analysis of data is not in our overall remit and we are currently not structured or resourced to perform this function. We feel that as the Ministry of health or MCNZ collects has direct access to data, for consistency and meaningful data analysis, we feel this function sits more appropriately with the Ministry or MCNZ.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

1) [redacted] is in general agreement the proposal and that the new framework could be made to work.
2) We are a membership based organisation and the relationships we have with our Fellowship are critical to the operation of our organisation. Requiring the College to assume a policing role would result in reduced collegiality, which is critical for the function of our College.
3) [redacted] recognises that this proposal is contemporary and that younger Fellows will be familiar with the concepts (audit, 360 degree, etc.).
4) DHBs will need guidance and there will need to be strong buy in from CMOs
5) DHB credentialing processes can be integrated somewhat with proposed requirements
6) Regarding point 1 on page 4 of the consultation document, we offer the following feedback:
    - 1.a .1 Re audit, sound audit processes would need to be developed and the processes need to be applicable to teamwork.
    - 1.a.11. Re-multisource feedback, good in principle. The [redacted] forms need rewriting so we request a suitable transition time to allow for development of these.
    - 1.1.111 Re feedback from a senior colleague, some CDs cautioned that this would not be useful if the colleague is removed from the actual work done by the doctor. Also, if the doctor goes to a close colleague or friend there could be bias. It was agreed that it would work well in hospitals and could be made to work by everyone, with a bit of thought and planning. There is value in "coffee conversations".
    - 1.b. Re identification of individual professional development needs, this is a practical suggestion. Some different views about whether this needs to show measures of achievement or change or it it's OK at a certain stage to go sideways or even backwards.
    - 1.c Re career management planning for all doctors, although there is general agreement about the concept there are also questions about the age that this should kick in. cognitive decline is not neatly measurable.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

As discussed in the above sections of this submission.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes, three years is adequate on the understanding that there is a graduated/stepped approach to implementation with clearly pre-defined milestones over the three year period.

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Submission to the Medical Council of New Zealand (MCNZ): March 2017

STRENGTHENING RECERTIFICATION FOR VOCATIONALLY REGISTERED DOCTORS

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback on the review of the current recertification requirements for vocationally registered doctors and proposal of new requirements and standards for medical college accreditation, proposed by the Medical Council of New Zealand.

ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients across Australasia.

Please find ACEM's responses to the consultation paper enclosed below.

If you require any clarification or further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager Fatima Mehmedbegovic on (03) 9320 0444 or fatima.mehmedbegovic@acem.org.au

Yours sincerely,

Dr Simon Judkins
President-Elect
Australasian College for Emergency Medicine

Dr John Bonning
Chair, New Zealand Faculty
Australasian College for Emergency Medicine

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Submission information
This submission is on behalf of: Individual □ Group ☑ **Name:** Dr Simon Judkins **Position/title:** President-Elect **Organisation:** Australasian College for Emergency Medicine **Do you agree to your submission, or parts of your submission being published**: Yes ☑ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Overall, ACEM supports the use of performance and outcome data to inform an individual's professional development plan (PDP). ACEM considers the use of performance outcome data reasonable as a general indicator; however, cautions against the use of these measures exclusively. In the context of emergency medicine, due to the multidisciplinary nature of the specialty, it is more difficult to attribute patient outcomes to an individual's practice. As such, outcome data may not accurately reflect an individual's performance, with multiple team members involved in a patient's care. Further, any assessment of an individual's practice must be measured within the context of their practice and benchmarked against colleagues in similar

institutions and/or circumstances. ACEM considers that structured peer review may be an appropriate method from which to derive the PDP.

ACEM also acknowledges that aspects of CPD undertaken routinely by all practitioners to remain current with contemporary practice, and which may be considered part of a more traditional (and passive) component of CPD, remain valuable to an individual's development. These activities should not be excluded from development of the PDP.

Logistically, ACEM agrees with medical colleges providing means through which doctors can document the PDP. However, ACEM is cautious of doctors' privacy considerations and would not support holding confidential performance data or patient outcome data in College IT systems.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Used as a formative measure, ACEM considers individualised PDPs a beneficial concept to assist doctors to actively plan their professional development needs. ACEM would caution against punitive measures for doctors who fail to achieve every aspect of the PDP. In introducing PDPs, careful consideration must be given to logistical arrangements, so as to ensure it is not overly onerous or time-consuming, as this has the potential to detract from the provision of quality patient care and, ultimately, detract from the fundamental purpose of recertification.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

ACEM acknowledges it is responsible for setting specialty practice standards. As such, ACEM is supportive of medical colleges defining knowledge requirements relative to their vocational scope of practice. ACEM views enforcement of this standard as the role of the Council and cautions against summative assessment of knowledge post-Fellowship.

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Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Resource implications are the most significant issue medical colleges will face in providing RPR for their members. Additional staff, both short and long term, will be required in the design, implementation and operationalisation phases of this work. In addition, new resources (e.g. expansion of IT platforms) may also be required. Thought would also need to be given to appropriate training of reviewers and the logistical implementation of such a system.

The above notwithstanding, ACEM is supportive of the use of Regular Practice Review (RPR) and its fundamental purpose.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

ACEM agrees in principle with providing additional support to its members as required; however, this is not without significant challenges. Whilst medical college may be well placed to undertake remediation activities related to deficits in the core competencies of their specialists (e.g. knowledge, skills, professional attributes), ACEM considers that it may not be best placed to facilitate the remediation of underperformance related to other factors (e.g. psychological, social or substance abuse issues), and that appropriately qualified organisations would need to be identified to remediate these issues.

ACEM acknowledges that it would be expected to have the primary role in assisting members (who don't meet the MCNZ referral threshold) with formal remediation. This could be via the delivery of education programs for specialist EM physicians and departmental Directors of EM, and in the development of context relevant resources for the management of underperforming doctors. However, ACEM considers that the ultimate responsibility would need to reside locally, within the respective health service, as employers are responsible for clinical governance in relation to performance and any associated formal human resources procedures that would be enacted. ACEM acknowledges that in the future, specialist colleges may have an increased role in the

independent assessment of complex performance issues, as an independent authority that would make recommendations to an employer in these matters.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

ACEM supports career management planning for emergency physicians; however, cautions against the use of a one-size-fits-all approach. ACEM supports an approach that works to better understand and identify all factors that increase doctors' risk of performing poorly, rather than age alone.

Emergency medicine is, by nature, a physically demanding specialty and as such, it is common for emergency physicians to gradually withdraw from clinical work over an extended period of time, generally at an earlier age than some other specialities.

ACEM also considers that employers have a significant role in assisting doctors' career planning, particularly with regard to industrial issues such as work hours or shifts.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

ACEM is supportive of medical colleges' monitoring and evaluating their recertification programmes, and agrees that supporting continuous improvement of programmes will ultimately assist in the recertification process. However, ACEM notes that medical colleges may be limited in the data they are able to collect, and that any collected data from the Council should be made available to the colleges. Clarification of any potential legal barriers to evaluation, such as privacy concerns, must also be considered.

Additionally, ACEM notes that evaluation will have resource implications, with additional staff required in the design and implementation (i.e. data collection and analysis) of the process.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

ACEM is generally supportive of the Council's proposal and would welcome further discussion with the Council as appropriate.
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
ACEM views the primary challenge to implementation as the significant resource implications for all medical colleges (particularly in staffing, systems and time), as well as for their members (predominantly time-based with the introduction of new requirements). Doctors will need to receive clear communication from the Council and the medical colleges to minimise opposition and hostility towards the additional requirements.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
ACEM agrees that three years from Council's final decision seems an appropriate and practical timeframe for transition.

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Submission information
This submission is on behalf of: Individual □ Group **X** **Name:** Professor Richard Doherty **Position/title:** Dean **Organisation:** Royal Australasian College of Physicians (RACP) **Do you agree to your submission, or parts of your submission being published**: Yes **X** No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes □ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The RACP supports **in principle** the use of performance and outcome data (where available), multisource feedback (MSF) and peer review to inform creation and review of an individual's professional development plan (PDP). While medical colleges are well placed to assist through provisions in their CPD programs, they have no outcomes or clinical performance data and aren't able to access any from employers or patients. Employers, District Health Boards and regulators all have relevant data. It is essential that performance and outcome data are accessible to doctors from all these relevant organisations in a

form that allows its use for the proposed purpose. Secure access to/ and sharing of data are essential elements in the success of this proposal.

Employers and Regulators compliance requirements (such as performance reviews, credentialing) need to be harmonised with College CPD requirements so that physicians do not have to create PDPs in different formats to meet different needs and in a way that maintains the balance between usefulness and onerousness. Any proposals must take into account the doctor's workload and that any additional compliance requirements be readily incorporated into the work pattern rather than being seen as an additional imposition or be resource draining. Outcomes are rarely directly attributable to an individual clinician at all, therefore careful consideration about what outcome data is meaningful in terms of a doctor's professional development needs should be undertaken with a focus on quality of care, communication with patients etc, and not just concentrating on volumes.

MyCPD is the current vehicle offered by the RACP for physicians to record their CPD activity. MyCPD incorporates current New Zealand specific CPD requirements (eg. completion of 10 hours audit activity each year). MyCPD also incorporates the ability to enter a professional development plan. This feature is currently not commonly used although the upgraded 2017 platform is designed to make the plan easier to complete and more relevant. The RACP understands that MCNZ requirements for incorporation of a PDP in MyCPD must be met and that using the PDP should be as user-friendly as possible.

It should be noted that for the non-procedural specialties, the challenge will be facilitating the peer review and quantifying outcome data.

It is also recommended that the MCNZ provide further guidance and examples of how to achieve this. For example, sample PDPs, pro formas and further guidance of how to have a "structured conversation" for the senior colleague to use in reviewing a PDP would be helpful so that each medical college does not have to invent its own. In addition, it is anticipated that preparing physicians, senior colleagues and external reviewers for implementation will require significant resources.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This is a reasonable, rational, and desirable and a well-established model for trainees. It also aligns with recent changes in CPD requirements with more emphasis placed on reflection. The development of a PDP should be initiated by the individual to identify their own learning needs, but there needs to be feedback from peers and line managers to assist in identifying goals and needs. There is evidence that having a plan is an important part for being effective and improving practice. The PDP can reflect this, but should allow for flexibility as plans and circumstances can change for an individual.

As indicated in the response to question 1, it will be essential that there is not duplication of requirements i.e. that a physician will be asked to complete a PDP in one format for their CPD and accreditation, and another format for annual hospital based performance reviews.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those

outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The RACP considers that it is essential that individual practitioners undertake CPD and recertification activities which are relevant to their individual scope(s) of practice.

It is reasonable that medical colleges define the knowledge requirements as these are defined within medical college training curricula. In addition, it is thought that the Colleges are best placed to understand what is relevant to their Fellows and what could be expanded to reflect continued learning. Colleges can also show leadership in developing CPD resources for the generic skills that all doctors should possess and display, however there should be further guidance from MCNZ with regards to this. One particular issue in New Zealand is MCNZ confers registration in the vocational scope of 'Internal Medicine', whereas in Australia the RACP oversees specialisation in different branches of medicine. This proves difficult for the RACP to align the knowledge requirements for a given speciality with the broad concept of recertification in 'Internal Medicine'. There may also be a difficult balancing act between subspecialty knowledge (that is best handled by subspecialty society (e.g. neonatal resuscitation guidelines for paediatricians)), and broader areas of knowledge (e.g. cultural safety) that need to be applied by all doctors.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The RACP believes it is a worthy recommendation to undertake regular RPR, especially for more isolated doctors; if a doctor feels under confident in a particular area; or concerns have been raised by colleagues (such as during credentialing). The RACP model of RPR, developed in conjunction with both CMC and MCNZ, currently under trial supports and encourages physicians in using performance and peer and practice review data to develop their PDP.

However RACP continues to have reservations about feasibility of this process for the 1,856 College Fellows in New Zealand and strongly suggests RPR remains an option as is proposed. The logistics of implementing RPR need to be costed realistically given the very significant resource implications for each of the medical colleges and the unresolved question of who would ultimately bear the cost. Other concerns raised are that some forms of RPR can be too complex, time consuming and costly for most doctors and their colleagues to complete or will not be very useful or objective. Employers would also need to make this time available and mandated within employment contracts.

In addition, based on the challenges encountered in engaging physicians to conduct practice review of overseas trained physicians applying for vocational registration in New Zealand, it is very unlikely that sufficient "senior" colleagues could be recruited and trained to undertake these reviews whatever model is uses. There is also the question of who would bear this cost.

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Physicians employed by DHBs (or universities) are also unlikely to support a model in which most of their CME funding for one year in three is required for such a purpose. The benefits of such a process over and above the other performance measures (such as the results of audit of medical practice and multi-source feedback from colleagues and patients) are not clear and would seem insufficient to justify practice review becoming a mandatory requirement. The RACP has had a model available for many years but the uptake has been very low. Even the proposal that there be a requirement to engage in some form of appraisal by an senior peer is likely to present problems in terms of the recruiting of sufficient numbers of suitably trained, "senior" physicians willing to carry out this role.

The RACP model of RPR being trialled has an annual individual Professional Development Review (PDR) and a three yearly service review – the Service Development Survey (SDS). While still in the trial phase, indications are that a majority of participating physicians have found the PDR to be a valuable exercise. A number of these participating physicians have reported their confidence is in part because it is a College led process.

A number of concerns have also emerged from the trials:

1. Work done to develop and trial the PDR, and associated MSF, has reinforced one size does not fit all. Significant further work needs to be done to develop customised approaches to meet particular physician group needs.
2. Locating available peer reviewers for the individual PDRs and the unit level Service Development Survey (SDS) has been very challenging and at some trial sites impossible. The difficulty of facilitating external peer review must not be underestimated.
3. The conduct of standard high quality RPR requires skilled, committed reviewers. As mentioned the development and support of these skills and the maintenance of consistency in the reviews for physicians who choose RPR will require a significant investment of resources.
4. A debrief of a candidate's MSF report by a trained 'advisor' has been identified in RACP trials as an essential element in its effectiveness. The identification of the advisors and the development of skills to debrief an MSF has further significant resource implications.
5. Health Services will not be in a position to easily work together with multiple different formats of RPR if each College adopts its own very individual framework. It is essential that the MCNZ identifies how it will manage this potential variation to avoid development of models that are not accepted in the workplace.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This is considered a good idea so long as adequate funding is provided to deliver such support. Again, this has the potential to strain the resources of medical colleges. The MCNZ and the medical colleges could consider collaborating to provide examples and resources which will show how to identify needs of individual practitioners and typical needs likely to appear at various career stages. Any support provided would need to be flexible and tailored as "one size does not fit all" at any life stage. There are however common themes for newly qualified specialists, for those making a career change or adding a new aspect to their practice and for those nearing retirement.

International data suggest that meaningful and comprehensive appraisal of performance will demonstrate that about 5% are performing "just good enough"; not so poorly as to endanger patients (and thus require reporting to the regulator) but at a level that is of concern and where any further deterioration may lead to issues of patient safety. How to manage such individuals appropriately is a major challenge. The initial aim, and for the majority the focus, should be remediation; the restoration of performance to an adequate level as soon as possible.

One issue raised in the "Strengthening of Recertification for Vocational Registrants" document is whether such persons should be reported to the regulator. Under current legislation mandatory reporting would not be required. If reporting is to be required there is the risk that individuals would be reluctant to disclose issues likely to adversely affect performance or to fully engage in the appraisal process. It is clear that many doctors are reluctant to "dob in" their colleagues even if they privately have some reservations about their performance. This highlights the need for culture change if these processes are to be successful.

On the other hand, oversight of the remediation process is required. There are numerous parties involved in such a process; the individual doctor, their clinical director, representative of the employer, occupational physicians, psychologist and other health professionals, mentors, support persons, College representatives etc. While it has been assumed that medical colleges will take a major role in such process, medical colleges are not directly involved in workplace activities and nor do they possess many of the "levers" or the resources to manage such a comprehensive process. A number of different parties are likely to be required, to a greater or lesser degree of involvement depending on the circumstances: the coordination of these to obtain the most appropriate outcome is the challenge. Whether this is best achieved by "formal" engagement of the regulator ("reporting"), is not clear but before any such system is introduced, much greater discussion of the "pros and cons" and wide engagement with the profession is required.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Chronological age is only one of many variables which may impact on a doctor's ability to undertake any activity so any review should not be based on age alone. Actual workplace performance can be impaired in many ways and while loss of technical competence is perhaps central, age-related diseases, failure to keep up through continuing education and other factors can contribute as well. An individual is commonly not the best judge of their own capability. A framework for recognising changes (e.g. in health, social circumstances) which have the potential to impact on a doctor's performance and require good collegial support and closer peer review would be useful. However, the proposed intervention framework will need to deal with concerns and provide an action point for medical colleges, employers, practice partners or associates to intervene if needed.

Further discussions could include whether certain procedural specialties may need some form of competence assessment to ensure procedural skills are maintained in an ageing workforce. Well-designed reporting and data collection processes will generally provide sufficient information on a practitioner's performance to allow detection of failing or diminishing skills, but additional review might even include physical assessments if appropriate.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the

purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The RACP agrees it is essential to look at the impact of the recertification programmes; particularly in terms of time required and demand for other resources for practitioners and for medical colleges. The outcomes of the programme, in terms of maintaining and improving standards of practice also need to be monitored over a prolonged period. It seems reasonable to review the programme yearly to ensure it is meeting MCNZ standards and has incorporated all the requirements.

The RACP suggests that the MCNZ form an oversight committee, composed of the key members of each medical college, so that general issues of CPD can be discussed and the experience and learning of each medical college be disseminated.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

The RACP believes this to be a well considered proposal aiming for an ideal recertification system. It aligns well with medical training programs and seems for now to be a sensible extension of this to the senior medical workforce. However, the vision and principles are likely to collide with the practical realities and logistics of implementing them, and envisaged benefits to individual physicians and the community may be difficult to deliver. The major concern is ensuring that clinicians and medical colleges have sufficient time and support to meet these increased recertification requirements. It will be important to make this part of a doctor's daily work stream as adding to the workload with requirements that are overly arduous and not evidence based will result in backlash or corners being cut. The role of employers such as District Health Boards in assisting the integration of these processes into the normal workplace is critical. Additionally, ensuring that good ideas and resources are shared between the medical colleges and MCNZ would save colleges re-inventing the wheel.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The RACP believes that there are numerous potential barriers to implementation which will need to be overcome. These include general cynicism amongst doctors regarding the underlying intent of the programme, a tendency for doctors to focus on traditional continuing education rather than professional development (especially CPD which examines workplace performance), concern about the potential that medical colleges might be expected to assume regulatory functions.

In addition, a number of key gaps will need to be filled, including repeated articulation of the community's expectations regarding recertification of doctors and publication of clear evidence supporting the likely effectiveness. Early staged communication and engagement within the workforce is also suggested, lead by motivated pilot doctors.

The financial cost of recertification and associated loss of productivity associated with compliance are also potential barriers to implementation. Any new program will need to be integrated into daily activities as much as possible and health services will need to allocate adequate time and resources for this. There needs to be evidence that this can be implemented in a meaningful way that does not become too onerous. It is anticipated an initial increase of retirements might occur because of this change in expected compliance.

Further consideration needs to be given to how factors that motivate doctors' engagement in CPD

might be identified and applied in this process. Consideration needs to be given to strategies to enhance practitioner involvement and to ensure that those engaged in crucial roles in the process have the requisite skills. In order to maximise the support of the profession, these activities may be best undertaken under the auspices of the medical colleges.

The RACP notes that misunderstanding about the relationship between the recertification framework, HDC processes, credentialing , privileged quality activities in the workplace, the regulator's process for handling complaints and mandatory reporting obligations is still quite prevalent. An unambiguously clear and readily accessible resource which addresses this would be very welcome.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

A staged approach is preferred; with the aim of 5 years completion.

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March 15, 2017

Karen Davis
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Medical Council of New Zealand
PO Box 10509
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By email: recertificationconsultation@mcnz.org.nz

Dear Ms Davis

Re: Strengthening recertification for vocationally registered doctors

Thank you for the opportunity to provide feedback on the above consultation. Please find attached a completed feedback form with comments from the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine (FPM).

The attached response is based on feedback from both the New Zealand National Committee of ANZCA, and the New Zealand National Committee of FPM.

If you have any questions or would like to discuss our submission, please contact Virginia Lintott (Senior Policy Adviser) in the first instance on 04 495 9790 or at vlintott@anzca.org.nz

Yours sincerely

Dr Gary Hopgood
Chair, New Zealand National Committee, ANZCA

Professor Edward Shipton
Chair, New Zealand National Committee, FPM

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Group **Name:** Dr Gary Hopgood (Chair, New Zealand National Committee, Australian and New Zealand College of Anaesthetists) and Professor Edward Shipton (Chair, New Zealand National Committee, Faculty of Pain Medicine). **Organisation:** Australian and New Zealand College of Anaesthetists, which includes the Faculty of Pain Medicine **Do you agree to your submission, or parts of your submission being published**: Yes **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
ANZCA agrees with the Medical Council's proposal that doctors should use performance data gathered via methods such as multisource feedback, audit and peer review to identify their professional development needs and inform their CPD planning. This is a logical proposal for ensuring that CPD programs are tailored to the individual learning needs of each doctor. This proposal should also be straightforward to achieve. For example, ANZCA already provides its CPD participants with guidance on how to identify learning needs, including considering whether the results of any practice evaluation activities or feedback from colleagues and patients has highlighted areas for further learning and

improvement, and encourages CPD participants to address these areas when developing their CPD plan. The College can further assist doctors by being available to discuss learning needs with CPD participants when extra help is sought.

ANZCA notes that section 1aiii of the Medical Council's proposal recommends peer review is undertaken by peers external to the doctor's usual practice setting. However, the subsequent sentences state the minimum is a structured conversation with a senior colleague, implying that external review is not mandatory. ANZCA recommends that the Medical Council clarifies its expectations and rationale in this area, and notes that while external peer review may be ideal in some settings such as in a small hospital or solo practice, review by a colleague within the same organisation may be more feasible to implement and also highly effective. It also aligns with the Council of Medical College's *Best Practice Guide for Continuous Practice Improvement*, which emphasises the value of a structured conversation with a colleague. Anaesthesia is in large part delivered by a sole practitioner and in the setting of a large hospital department, there may be many other practitioners who may work in the same organisation but are essentially external with respect to the doctor's usual practice environ. ANZCA also notes that peer review need not be performed by a "senior" colleague, and that "senior" can be difficult to define. NZNC members considered there to be value in peer review by any peer registered in the appropriate scope of practice as a consultant, even if that peer is more recently qualified than the person they are reviewing.

The Medical Council's proposal to use outcome data to identify individual performance needs is likely to be more challenging. ANZCA assumes that when the Medical Council refers to outcome data, it is specifically meaning patient outcome data. There are a number of reasons why it would be problematic to base individual learning needs on patient outcome data at this stage.

Currently, there is a lack of registries for collecting good quality patient outcome data that doctors can use to assess their individual performance. Developing registries to collect data will be resource intensive for the health system, and will require careful thought about how to collect good quality, meaningful, user-friendly data as part of normal practice. Resource implications for management, analysis and reporting of collected data will also need to be considered. The absence of registries that can provide this data currently, and the considerable time and resource to establish such registries, means that, in anaesthesia and pain medicine, it is unlikely doctors will be able to identify their individual CPD needs based on patient outcome data at this stage.

ANZCA supports the concept of collecting high quality medical outcome data to improve the quality of health services, patient outcomes, and benchmark practice. However, even if robust registries were developed, it would still be difficult to use the registries to identify the needs of any individual health practitioner for CPD purposes. Medical interventions in anaesthesia and surgery are, in the main, delivered by teams rather than individuals, meaning that medical outcomes are not solely dependent on one specialist. Patient outcome data is likely to have more utility and context in assessing and improving performance at a team and organisation level, rather than at an individual level. Furthermore, to have enough statistical power to detect performance issues, doctors would need to have a fairly high caseload of any specific procedure for a difference in patient outcomes (e.g. mortality rates) to be shown, especially for procedures where baseline mortality rates are low. Again, the caseload required for adequate statistical power to detect differences in outcomes, means outcome data is more likely to be useful for comparing performance at a team or unit level, rather than an individual level. Mandating

action on outcome data in the setting where it is of poor or meaningless quality may offer the unintended consequence of risk to patient quality of care.

In terms of patient outcome data, ANZCA also notes that the Ombudsman's June 2016 Official Information Act opinion about surgical outcome data recommends that the Ministry of Health and the Health Quality and Safety Commission lead health sector work on collecting outcome data that "are meaningful to health care consumers; - are meaningful to the clinicians who provide their care; - are meaningfully attributable to the clinicians or service providing that care; and - increase the availability of information to the people of New Zealand."

Based on the above, ANZCA considers the Ministry of Health and the Health Quality and Safety Commission have been charged with taking a broad, strategic approach to establishing how patient outcome data can be meaningfully collected and utilised for quality improvement. It is likely little would be gained by expecting medical colleges to attempt to address this issue in a short timeframe as part of individual CPD programs. However, once the New Zealand health sector has established ways to meaningfully collect outcome data, ANZCA would support clinicians undertaking meaningful personal audit referenced to national benchmarks, where available.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

ANZCA supports the Medical Council's proposal that vocationally registered doctors should develop a professional development plan that identifies their professional development needs. Once again, this is a logical proposal for tailoring CPD activities to the learning needs of the individual. It is also appropriate that doctors should review their professional development plan regularly to ensure they are meeting the needs they identified in the plan, and that the plan remains fit for purpose. Developing and reviewing PDPs should also fit well with employer performance appraisal processes.

ANZCA's CPD program already requires participants to develop a CPD plan, and provides guidance on how to identify learning needs. ANZCA has also developed a document *Supporting Anaesthetists Professionalism and Performance: a Guide for Clinicians*. This is a performance framework that assists anaesthetists to improve their practice of anaesthesia, perioperative medicine and pain medicine. It supports self-assessment, peer assessment and assessment by others, promoting reflective practice, planning and guiding remediation. It provides guidance on identifying learning needs, and a framework for examining outcomes from multisource feedback. It also identifies resources to help trainees and Fellows with professional development.

As above, ANZCA considers it reasonable that doctors' PDPs should be informed by qualitative performance data from audit, multisource feedback, patient feedback, and peer review. However, at this

stage it would be unrealistic to assess performance and identify learning needs based on patient outcome data.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Medical colleges already define the knowledge requirements for their vocational scopes of practice via curricula, standards and guidelines. ANZCA links these knowledge requirements with its CPD program, for example by providing guidance on how the CPD program maps to the roles in practice identified in ANZCA's curriculum (medical expert, communicator, collaborator, manager, health advocate, scholar, and professional). ANZCA also provides standards and learning objectives for the emergency response category of its CPD program, and resources for cultural competence.

However, in terms of the specific documents mentioned above, such as the Code of Health and Disability Consumer's Rights, and the Medical Council's statements, ANZCA considers there may be merit in the Medical Council taking a national approach to defining the knowledge requirements for these documents. The knowledge requirements for the legislative framework that governs health practitioners should be consistent across vocational scopes, and should also apply to those doctors who are not registered in a vocational scope. Moreover, it would seem an unnecessary duplication for each College to identify the required knowledge base, and orchestrate standards and evaluation and assessment tools independently. For that reason, ANZCA considers the Medical Council is best placed to define a national approach that applies to all doctors. Such an approach might benefit from collaboration with the Council of Medical Colleges in a continuation of the collaboration which produced the *Best Practice Guide for Continuous Practice Improvement*. The Medical Council also has a lever available to ensuring all doctors familiarise themselves with legislative requirements, by potentially making it part of the requirements for renewing annual practising certificates.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

ANZCA recognises that it is difficult for some individual medical practitioners in some settings to assess their own performance and objectively identify their learning needs, and therefore considers direct peer review to be a valuable part of CPD. ANZCA has peer review of practice as an option in its CPD program.

In terms of Regular Practice Review (RPR) specifically, it is unclear from this proposal whether medical colleges would be expected to provide tools to assist with RPR, or to actually perform RPR's. ANZCA also has concerns about the resource implications for the health sector. Based on the principles outlined in the Medical Council's RPR policy, achieving quality RPR is time consuming for both the assessor and the individual being assessed. Although at this point the Medical Council is suggesting voluntary RPR, it will still be important to consider what impact a large uptake in RPR would have for the health sector, and how this would be resourced. Because RPR is resource intensive, it will be essential to demonstrate that RPR achieves measurable benefits in terms of practitioner performance, and patient safety. Simply identifying that an individual found the process engaging, and intends practice change, of itself is poor evidence of worth. We note that the Medical Council's recent evaluation of RPR found that 12 months after a Regular Practice Review, 55% of doctors reported no change to practice. The value judgement required to justify such use of time needs to be robust when applied to a resource constrained healthcare system, although the frequency anticipated by "regular" and the definition of "external" would be key factors. A broad definition of external and triennial approach as mandated for general registrants may well be more easily supported with existing resources.

Many college CPD programs are likely to already include elements of principles included in the Medical Council's RPR policy. For example, ANZCA's CPD program includes peer review of practice, multi-source feedback, audit, patient experience surveys, and emergency response activities that involve a component of external peer review and feedback. Also, employers have processes that cover elements of the Medical Council's RPR principles, including performance appraisal. District Health Boards with robust credentialing and recredentialling processes for their employees, in line with the Ministry of Health's *Credentialling Framework for New Zealand Health Professionals*, are also likely to cover most of the Medical Council's expected elements of RPR.

ANZCA has endorsed the Council of Medical Colleges' *Best Practice Guide for Continuous Practice Improvement*, which focuses on the concept of a constructive conversation with senior peers, and aims to reduce the duplication medical practitioners experience when meeting the various requirements set by their employers, colleges, and the Medical Council. ANZCA recommends that the Medical Council uses the CMC best practice guide to adjust its RPR policy, broadening its definition of practice review, thereby reducing duplication. Such an approach, acknowledging that processes that already exist can form a suitable component of RPR, may make RPR more feasible, cost-effective and time-efficient.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The nature of the additional support medical colleges would provide doctors is unclear from the proposal, and could be further defined. It is a reasonable expectation that medical colleges will be able to help their CPD participants to identify their professional development needs, and it is likely that many colleges already do this. For example, ANZCA provides templates and guidelines to help doctors identify learning needs and plan continuing professional development, and also provides resources for specific career stages, such as *PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists*. Furthermore, staff and Fellows involved with the CPD unit are available to discuss these issues with individual CPD participants and provide advice as needed.

However, if additional support is referring to managing competence and performance issues, this is a more complex issue. ANZCA can provide education on managing competence and performance for directors and heads of department but the competence and performance issues are best placed to be managed through employer processes such as performance appraisal and credentialing. Employers are more likely to be aware of potential issues and able to address them directly at the local level. More serious issues are best dealt with through the Medical Council and Health and Disability Commissioner complaints processes enshrined in legislation, and it would be inappropriate for recertification programs to be viewed as a mechanism for remediating problematic behaviour. ANZCA considers there is certainly a role for the College to provide support to those who have already been through employer-led performance appraisals, or regulatory authority processes, and been referred to the College for guidance.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

In general, ANZCA supports the proposal that career management planning is required for all doctors, as a component of ensuring a safe, fit-for-purpose workforce. However, the Medical Council's description of career management planning in section 1c emphasises the ageing doctor, but underplays the need for all doctors to manage a career plan. Ageing alone is not the only reason to revisit workload, hours and case-mix. Social and health issues can affect performance at any age.

In terms of mandating certain activities as doctors age, and encouraging discussions about transitioning to retirement, the Medical Council's expectations will need to be carefully balanced with human rights legislation. Under the Human Rights Act 1993, it is unlawful to discriminate employees, volunteers and job applicants based on age. This legislation applies to employers and vocational training bodies. Mandating certain activities and discussion about retirement based on age, could be open to allegations of discrimination.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

ANZCA agrees that it is good practice to evaluate recertification programs and support continuous quality improvement.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

For section 8: completion of CPD activities, it would be useful to provide more detail about the Medical Council's expectations for medical colleges in supporting doctors to implement their PDP and make satisfactory progress towards their PDP goals. ANZCA currently does this by providing guidance for developing a CPD plan (a mandatory component of the CPD program), and requiring participants to evaluate whether they have met the requirements in their CPD plan (also a mandatory component of the program).

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Depending on the final position, and the specific requirements to meet the MCNZ's Regular Practice Review Policy, then cost could be a barrier. This could be mitigated by using existing employment performance appraisals, or credentialing, as mentioned above. Internal or local resources could also be used in the first instance, as external resources tend to be costlier and may not offer significant advantage over internal resources.

In general terms, the Medical Council will also need to clearly define the different roles of the Medical Council, the colleges, and the employers, to avoid any ambiguity and therefore facilitate effective implementation of its revised approach to revalidation.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Three years seems to be a reasonable timeframe.

17 March 2017

Karen Davis
Senior Project Manager
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Via email: recertificationconsultation@mcnz.org.nz

Dear Ms Davis

Strengthening recertification for vocationally registered doctors

The Royal Australasian College of Surgeons (RACS) is pleased to provide feedback on the Medical Council of New Zealand's (MCNZ) consultation on strengthening recertification for vocationally registered doctors.

RACS is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates across New Zealand and Australia. As part of its commitment to standards and professionalism, RACS strives to take informed and principled positions on issues associated with surgical standards and the delivery of health services.

Participation in recertification activities cannot ensure competence but it definitely contributes to this. RACS acknowledges the importance of recertification activities and supports the MCNZ's stance that this needs to be profession led and sees this best achieved through the combined efforts of medical colleges, the MCNZ and , where relevant, employers. While all want to strive for best practice, this of course has to be balanced against potential limiting factors such as costs in time and resources.

In the sections below RACS has responded to the MCNZ's specific question and other proposals within the consultation document.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

RACS recommends that an individual Professional Development Plan (PDP) is an optional requirement for an approved recertification programme for the following reasons:

RACS currently requires all those participating in the College's recertification programmes (CPD and MOPS programme) to participate in at least one activity in Reflective Practice. Options for Reflective Practice include "Development of a structured Learning Plan including self-reflection". RACS assists by providing an online Learning Plan based around the nine RACS competencies:

- Medical Expertise
- Judgement – Clinical Decision Making
- Technical Expertise
- Professionalism
- Health Advocacy

- Communication
- Collaboration
- Management and Leadership
- Scholarship and Teaching

Fellows select the competency/competencies they wish to focus on and develop specific learning goals. CPD activities completed during the year are mapped by competency and those relevant to the Learning Plan are automatically populated through to the plan.

At stages throughout, and at the end of the year, Fellows review their activities and reflect on whether they have achieved their goals.

The MCNZ consultation document proposes that medical colleges are required to ensure "feedback from a review undertaken by peers external to the doctor's usual practice setting"; and, as a minimum, this external review should be "a structured conversation with a designated senior colleague". RACS considers this to be excessive, both in clinician time, staff time and cost. It is not possible for RACS to provide this to all Fellows on an annual basis to inform the annual performance plan.

RACS acknowledges the value of auditing clinical outcomes. However, as the MCNZ will be aware from the HQSC's publication on the public reporting of clinical data in 2016, data related to an individual clinician needs to be appropriately risk adjusted to account for patient complexity and procedural numbers. It is also known that a clinician's performance data can change based on the team that they are working with (ie: the same clinician can achieve varied outcomes with different teams). Patients are often cared for by a number of health professionals and their outcomes are dependent on teamwork and good communication, not an individual doctor. Furthermore, there are areas of clinical practice where outcome data is not yet readily available or meaningful. These factors need to be considered when an individual reviews the clinical outcomes for their patients.

In 2016 RACS successfully piloted a multisource feedback (MSF) tool based on the nine surgical competencies. Over 100 surgeons participated in the pilot which received favourable feedback. RACS will expand the pilot in 2017, particularly focusing on ways to improve the feedback loop. The MCNZ consultation document lists results from MSF as one of the minimum activities to inform individual PDPs. These Plans would be reviewed annually, but it would be excessive to undertake an MSF on an annual basis.

RACS has been working with a number of 'big data' providers in Australia (eg: health insurance companies), the main outcome of these partnerships to date being the development of a suite of surgical variations reports which allows surgeons to compare some aspects of their practice against their peers. RACS will continue to progress this work and is also exploring options in New Zealand.

RACS developments to date on its Learning Plan and multisource feedback tool have required considerable time and financial resourcing. There is still work to do on these. If the MCNZ decides to proceed and make an individual PDP a compulsory requirement, we do not believe that it will be feasible for RACS to have all systems developed and incorporated into the RACS' bi-national programme in just over three years.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

RACS supports individualised PDP being an optional activity at this time. While we recognise the value of these in self-reflection (which should be encouraged of the all medical practitioners), reflective practice activity can take many forms and should not be primarily focused on PDP. There may also be areas of cross-over where employers require annual performance plans; where this is in place, it is important not to duplicate effort.

MCNZ is proposing that a PDP be informed by "performance and outcome data". Such data commonly refers to clinical outcomes. The RACS Learning Plan has a wider perspective as Fellows can also focus their Plan on competencies for which there is no clinical outcome data (eg: professionalism, collaboration etc). Therefore, RACS believes that the MCNZ's proposal to base learning plans on outcome data is too narrow.

The consultation document also proposes medical colleges will need to ensure each of their Fellows "makes satisfactory progress towards their PDP goals each year". RACS does not support this being a requirement for accreditation of its recertification programmes. It is willing to provide systems to support individual practitioners and monitor compliance with the program, but does not see itself as the watchdog for achieving individual goals.

Question 3:
What is your view of medical colleges defining knowledge requirements?

RACS recommends that the MCNZ develops its own system to assess understanding of Council statements and other documents, and the Code, so that there is a common standard applied across all vocational scopes.

The knowledge requirements for each of the RACS' nine surgical specialties are already identified within the relevant training curriculum. These curricula are built around the nine RACS competencies and which are also reflected in the recertification programmes.

The MCNZ lists five domains of competence which are all present within RACS' nine competencies. The RACS Code of Conduct also requires that all Fellows are aware of their jurisdictional requirements and legal responsibilities. This includes the expectations identified in documents such as the *Code of Health and Disability Services Consumer's Rights* and *Good Medical Practice*.

RACS is committed to improving health equity for Māori, and for Aboriginal and Torres Strait Islanders. This is reflected in its Māori Health Action Plan and Reconciliation Action Plan. Cultural competency is of course wider than indigenous populations. RACS already has some e-learning resources available to all Fellows and Trainees and continues to explore further resources.

RACS is of the view that its general approach is preferable to listing specific documents and publications.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RACS has no issue with the provision of a Regular Practice Review (RPR) as an optional requirement for recertification.

For one surgical specialty in New Zealand (orthopaedic surgery) RPR is already a compulsory component of the recertification programme. For others, an RPR is an optional activity in the reflective practice category of RACS' recertification programmes. The RPR is not "provided" by the College. In most instances, other than Orthopaedics in New Zealand, it is left to the practitioner to arrange this activity. At this time, RACS does not provide a model for its vocational scopes. This would need to be developed if it became a requirement for accredited recertification programmes.

RACS supports the proposal that RPR be a voluntary CPD activity. At this time, RACS does not support the College being the provider as we recognise that RPR may be available through a range of providers (including employers).

In its consultation document, the MCNZ has suggested that an RPR could occur every three years. RACS considers that, with the time and resources required, this is too frequent.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

RACS employs two Executive Directors for Surgical Affairs (EDSA) – one based in New Zealand, one in Australia. These roles provide support for Fellows, which can include offering assistance with professional development. RACS' guidelines in its policy on Re-skilling and Re-entry list the EDSA's as the initial contact point.

RACS' Professional Development and Standards Board (PDSB) will arrange peer reviewed audit for surgeons who work in isolation. RACS also has a locum audit committee for those surgeons who occupy

only short-term positions. Furthermore, the RACS document "Mentoring – a practical guide" is a practical toolkit for providing or seeking mentoring support.

RACS also organises and runs a number of professional development activities, some of which are provided free of charge or are subsidised, across a range of activities. These are available to all Fellows and IMGs in the MOPS programme.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

There has been considerable discussion around suggestions of compulsory age-related testing (eg: for sight, cognitive function etc). The RACS position paper "Senior Surgeons in Active Practice" supports an annual health check and ophthalmic assessment for these practitioners.

Older surgeons can make considerable contributions to health service delivery. Their experience and knowledge should be utilised for the benefit of the health services.

RACS acknowledges the importance of career management and believes that this should not be restricted to the older doctor.

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

RACS has a robust verification process with 7% of Fellows' CPD audited annually.

RACS acknowledges that it is good practice to evaluate programmes. RACS' recertification programmes are reviewed by its PDSB. In addition, RACS' regular Fellowship Survey includes questions related to CPD. The responses to these questions are also considered by the PDSB's review of recertification programmes.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

In general, RACS supports the vision and standards for recertification. However, principle (3) "Recertification is informed by relevant data" has limitations as performance and outcome data is not available for some competency domains (eg: professionalism); see further comments under Question 1. However, there are comments above that relate to elements within the "Vision and Principles for Recertification".

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Depending on the requirements of the MCNZ decision, there will be costs associated with implementation (eg: development of computer programmes, additional staffing etc). As these CPD processes are funded solely from member's subscriptions, the cost of implementation may well be a barrier.

In relation to the "additional criteria" for all recertification programmes (section 10 of the consultation document), RACS already fulfils, or is able to fulfil, the following requirements:

a) informing MCNZ of the categories and numbers of practitioners undertaking the RACS recertification programmes;

b) informing MCNZ of any practitioners not enrolled in the RACS recertification programmes;

c) allowing vocationally registered non-fellows to participate in the RACS recertification programmes;

d) having a process for auditing and reporting to the MCNZ if practitioners are participating and meeting the requirements of the RACS recertification programme; and a system for dealing with those who are not;

f) having a system for informing MCNZ if RACS became aware of performance / competence concerns on the part of a practitioner; and

g) providing evidence to MCNZ that a delegated recertification provider meets MCNZ requirements.

While RPR is an optional activity within the RACS, recertification programmes, RACS is not the provider of those reviews so is not in a position to report numbers and outcomes. Even if it was, it would not necessarily be in a position to inform the MCNZ on the outcomes as it is possible that the RPR would be a Protected Quality Assurance Activity.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

As stated above, there are proposals which are not supported to be mandatory. Whether RACS considers the proposed three years, from the time of decision, to be sufficient will depend on which of the proposals the MCNZ enacts.

RACS thanks the MCNZ for the opportunity to comment on these important matters. If you require any further information please don't hesitate to contact the RACS.

Yours sincerely

Cathy Ferguson FRACs
Chair
Professional Development & Standards Board

Randall Morton FRACS
Chair
New Zealand National Board

RACMA
The Royal Australasian College of Medical Administrators

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10 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
NEW ZEALAND

Sent to: recertificationconsultation@mcnz.org.nz

Re: RACMA Submission to the Medical Council of New Zealand's Consultation, Strengthening Recertification for Vocationally Registered Doctors

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college of more than 1,000 Fellows, Associate Fellows and trainees in public and private health settings across Australasia. The College sets standards and provides professional development and specialist qualifications in medical management and leadership to registered medical practitioners.

RACMA's Fellows are registered medical practitioners trained in the recognised specialty of medical administration. The specialist role of medical administration includes expertise in clinical governance, engagement and performance management of medical staff, and credentialing.

The integration of medical and management expertise enables the medical administrator to work through others to accomplish complex outcomes while simultaneously being accountable and accepting responsibility for a medical services' outcomes. While medical management is not directly involved in the diagnosis and treatment of patients, the clinical skills and knowledge inherent in medical training separate medical managers from other health service executives. Medical administrators work across procedural specialties – as a consequence they have no agenda other than for the health system to work effectively, and for it to deliver optimally to the many people with a stake in the system.

RACMA welcomes this opportunity to respond to the *Medical Council of New Zealand's Consultation on Strengthening Recertification for Vocationally Registered Doctors*.
RACMA agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

RACMA is supportive of an approach that both strengthens and individualises recertification so it is relevant to an individual doctor's practice. RACMA's continuing education program incorporates many of the features in the proposal, and the College is happy to work with the Medical Council of New Zealand in the implementation of these requirements.

Areas that RACMA would like to highlight as considerations in the implementation of the proposed requirements set out in the consultation paper are:

1. *Diverse roles and work settings of RACMA's vocationally registered medical administrators*

   RACMA's vocationally registered medical practitioners are employed in particularly diverse roles, and the areas of work may differ across the specialty. Specialist medical administrators often work at a level where their work and decisions affect the broader system and hence a whole community, rather than an individual patient. The outcome of their work and decisions may be influenced by factors that are beyond the control of the individual specialist administrator.

   This means that specific consideration needs to be given as to the need for a variety of measurement of performance and outcomes, and these may need to be progressively developed over time.

2. *Medical practitioners who are not affiliated with the College but working within the scope of medical administration*

   RACMA raises this as a potential issue to the Medical Council NZ achieving the objectives of strengthening recertification in New Zealand. There may be medical practitioners working within the scope of practice of medical administration who are not recently credentialed nor meeting the professional continuing professional development (CPD) standards of the medical administration specialty.

   Typically, this will be a senior clinician who has taken an administrative or management role within their specialty, such as Director of Surgery, or Director of Obstetrics. However, also includes medical practitioners working in full time roles, such as Chief Medical Officer. These practitioners may be compliant with the clinical CPD requirements of the relevant College, but may not have any formal medical administration training or ongoing CPD.

   It is important that it is acknowledged that their role affects both the safety and standard of care delivered to a community, and their recertification needs to include CPD that is relevant to working within the vocational scope of practice of medical administration.

Thank you for the opportunity to comment.

Yours sincerely

Dr Karen Owen
Chief Executive

Dr Grant Howard
Chair, NZ Jurisdiction Committee

Encl: Detailed response to the Consultation, *Strengthening Recertification for Vocationally Registered Doctors*

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to
recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual □ Group X **Name:** Karen Owen **Position/title:** Chief Executive **Organisation:** Royal Australasian College of Medical Administrators **Do you agree to your submission, or parts of your submission being published**: Yes X No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
RACMA's Response: RACMA Fellows are required to remain in good standing with RACMA. A significant element in this requirement is completion of 50 points of CPD annually, agreement to log points mapped to categories in the College CPD standard and an annual e-audit ahead of issuing annual CPD Certificates. RACMA also undertakes random audits requiring evidence of CPD.

RACMA supports the concept that practice performance data and reflection can be used to inform the individual's professional development plan. The RACMA CPD Standard identifies forms of peer review and audit within its standard. RACMA has commenced to deliver a peer review and audit program. This has included 360, peer learning sets, an audit and peer review program.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

RACMA's Response:

RACMA encourages all its members – from trainees to Fellows to develop annual professional development plans. Facility is provided for this in the RACMA e-CEP tool. To date this has been highly recommended and we will maintain this position. Newer Fellows graduating from the Fellowship Training Program are familiar with annual PDPs and review. We anticipate as the newer population of RACMA Fellows moves through the College the benefit of these PDP will be well recognised and normalised.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

RACMA's Response:

RACMA advocates for a profession led approach both in NZ and Australia. RACMA Fellows shall be able to define the specific scope of their practice within the specialty field of medical administration. This scope will then inform their PDP and their selection of CPD activities.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RACMA's Response:

RACMA has commenced development of a form of RPR for medical administrators. A pilot of a practice visit program has commenced in 2017 and feedback is positive. In addition RACMA has as recently as last week piloted an audit and peer review program which has also been positively received.

The initial challenges posed by RACMA Fellows relate to 'just what' will be the subject/data of the visit/reviews. We are working through this and while it is early days the progress for those Fellows engaging is most positive.

RPR is likely to be an expensive undertaking and option suited more to some Fellows than others – a reflection of their scope of practice. Training of visitors and visitees, documentation, co-ordination and oversight are all matters to be considered.

A transition period to provide for cultural change and preparation will be required.

RACMA in principally agrees that RPR as one option for its Fellows to undertake on a voluntary basis.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

RACMA'S Response:

Colleges may be well placed in a profession led approach to improving performance. Partnership in this regard with regulators is appropriate although not always necessary. A majority to RACMA Fellows are employees and subject therefore to both employer, regulator and College performance management requirements/supports.

In time as College CPD programs are enhanced, opportunities may emerge for the College to earlier identify doctors specific development needs. RACMA is considering development of a professional standards advisory function.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain

activities as doctors age? If so, what activities and what age should apply?

RACMA's Response:

No as there is such diversity. What is the evidence to suggest this is cost effective and appropriate?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

RACMA's Response:

RACMA is an advocate for quality and safety systems improvement in health services management practice. RACMA is accredited by both MCNZ and AMC and reports annually on developments and initiatives to strengthen and improve its programs.

Encouraging a culture of continuous improvement therefore is supported. The challenge is that the ROI on such investments in change may not be immediate on the outcome side.

A means to encourage (rather than mandate) continuous improvement in the highest risk areas of an operation may then be supported.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

RACMA's Response:

RACMA is supportive of an approach that both strengthens and individualises recertification so it is relevant to an individual doctor's practice. RACMA's continuing education program incorporates many of the features in the proposal, and the College is happy to work with the Medical Council of New Zealand in the implementation of these requirements.

Areas that RACMA would like to highlight as considerations in the implementation of the proposed requirements set out in the consultation paper are:

1. Diverse roles and work settings of RACMA's vocationally registered medical administrators

RACMA's vocationally registered medical practitioners are employed in particularly diverse roles,

and the areas of work may differ across the specialty. Specialist medical administrators often work at a level where their work and decisions affect the broader system and hence a whole community, rather than an individual patient. The outcome of their work and decisions may be influenced by factors that are beyond the control of the individual specialist administrator.

This means that specific consideration needs to be given as to the need for a variety of measurement of performance and outcomes, and these may need to be progressively developed over time.

2. Medical practitioners who are not affiliated with the College but working within the scope of medical administration

RACMA raises this as a potential issue to the Medical Council NZ achieving the objectives of strengthening recertification in New Zealand. There may be medical practitioners working within the scope of practice of medical administration who are not recently credentialed nor meeting the professional continuing professional development (CPD) standards of the medical administration specialty.

Typically, this will be a senior clinician who has taken an administrative or management role within their specialty, such as Director of Surgery, or Director of Obstetrics. However, also includes medical practitioners working in full time roles, such as Chief Medical Officer. These practitioners may be compliant with the clinical CPD requirements of the relevant College, but may not have any formal medical administration training or ongoing CPD.

It is important that it is acknowledged that their role affects both the safety and standard of care delivered to a community, and their recertification needs to include CPD that is relevant to working within the vocational scope of practice of medical administration.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

RACMA's Response:

RACMA emphasises the importance/significance of scope of practice. The College continues to advocate that all vocationally registered practitioners who actually practice in an alternative scope (e.g., Medical management), be required to associate with the relevant college (i.e. RACMA) and be supported through its professional practice programs/CPD. RACMA has the means to address this through its Associate Fellowship and Fellowship programs.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

RACMA's Response:

This should be ok. However some flexibility to vary if necessary is appropriate. At this stage RACMA

is not absolutely clear on what the Council will decide (if this is a consultation process) and, within that decision, what the relative weighting of mandatory: voluntary requirements will be.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Group ☐ **Name: Andrew Stacey** **Position/title: Convenor of the Professional Standards Committee** **Organisation: Royal New Zealand College of Urgent Care** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Having hard data to inform the PDP would be useful but Medical Colleges will need to assist doctors to identify what data it is relevant to collect eg PSS data, peer review feedback etc, rather than leave individual doctors to decide what is relevant or helpful. Colleges also need to provide assistance about what formats this data should be collected in to enable useful analysis.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

An individualised PDP is essential for every doctor and should form part of recertification- NZRCUC already requires this. Fellows have found the PDP useful to assist reflection on past progress (or otherwise) and plan CPD activities and audits for the next 1-3 years. However given the broad underlying similarities within scopes of practice there should be direction by colleges to Fellows about what activities and goals are desirable within any PDP which should then be balanced against individual differences and needs. Additionally colleges should develop more mechanisms to analyse PDPs and feed back to doctors on whether an individual's PDP is adequate or not.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Essential. RNZCUC already defines these requirements and directs trainees and Fellows towards learning aids to assist acquisition and maintenance of the core knowledge requirements. The difficulty lies in defining the depth of detail of that knowledge so it is clear to an individual practitioner. Colleges need to give clarity about what is core knowledge and skills and to what level doctors are expected to be competent in each area.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RPR is an excellent tool for direct observation of a doctor's practice albeit in a slightly artificial environment

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

and this can also be stressful for the doctor concerned which may then distort their performance. The cost of this is also generally significant whether born by the college (and hence the doctor indirectly) or the doctor directly. Increasing compliance costs are already a substantial burden on practitioners and RNZCUC does not favour raising these without very good justification. Ideally RPRs are used only as a tool for colleges to assess poor performers or when an area of concern has been identified.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

In our view colleges should provide additional support for doctors both generically and specifically. Generic support taking the form of access to CPD and activities that support recertification and forums that enable engagement eg peer review and collegiality. Specific support should also be provided that can be tailored to a doctor's individual needs eg support for developing areas of subspecialisation within their scope and professional support while impaired eg through illness or mental health issues. The college should also have a role, in our view, in providing support for doctors who are at a later stage of their careers when facing challenges such as a reducing clinical work load balanced with maintaining core competencies. The college being able to support senior doctors transitioning to more administrative functions within their scope or to a greater academic workload will also assist with retaining experienced practitioners who still have much to offer younger colleagues and the branch.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

See above comments. Colleges should assist older doctors by developing guidelines around career planning relevant to their age. While there are studies supporting a general decline of cognitive function and competence as doctors age, this is not a universal finding and should not be used to tar all senior doctors with a "potentially incompetent" brush. Encouraging the proactive self-reporting to colleges of significant health conditions is a positive approach. Retrospective interventions and support from colleges once concerns have been identified is a more appropriate interventionist strategy in assisting older doctors with career planning.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Colleges will need guidance on what data that is effective in evaluating recertification has been shown nationally or internationally to be effective.
Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?*
Overall we support the proposal.
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
The major hurdle will be assisting colleges to be able to decide on what data to collect and how best to analyse it to support the processes identified. Implementing mandatory PDPs and an optional RPR is an excellent development.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes

16 March 2017

Ms Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO BOX 10509
Wellington 6143

By email to: recertificationconsultation@mcnz.org.nz

Dear Ms Davis

Thank you for your opportunity to comment on the Medical Council of New Zealand's consultation paper on *Strengthening Recertification for Vocationally Registered Doctors in New Zealand.*

In 2015, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) provided feedback on your earlier consultation on the Medical Council of New Zealand's (MCNZ) vision and principles for recertification and we support your progression towards an evidenced-based approach to CPD activities.

The RANZCP has responded to your questions and we have also made some general observations.

Introduction

The aim of the Health Practitioners Competence Assurance Act (the Act) is to provide the mechanisms to ensure that health professionals are competent and fit to practice. Responsible Authorities (the regulators) have set standards of competence whereby a health professional must certify they are engaging in CPD activities before they may be issued an annual practising certificate.

We agree with your principles outlined on page 3 of your document. Recertification must be profession-led and with this there are responsibilities, mainly to the public to demonstrate as doctors we are committed to quality improvement and improving competence. Davis in his paper outlines how professional autonomy may be eroded by public perception if the medical profession does not focus on building a competent workforce (Davis 2011).

Recertification or CPD activities are always formative not summative. The RANZCP's CPD program provides a pathway that supports psychiatrists to "*review and further develop their professional practice to ensure a high standard of psychiatric practice in order to achieve the best attainable quality of psychiatric care and patient outcomes '*(RANZCP, 2013). The focus of our CPD program is on quality improvement and continuous learning rather than measuring and assessing the participants and this is a critical concept that must underpin all CPD activities.

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The RANZCP argues that the recertification or CPD Program that we currently operate meets the standards outlined in the MCNZ's vision as we have developed a flexible yet comprehensive program that includes the following components: Professional Development Plan (PDP), Formal Peer Review, Practice Development, Quality Improvement & Review and Self–Guided Learning.

The RANZCP contends that the review of the recertification standards sits well with the Ministry of Health's Health Strategy that seeks through best practice to improve health equity, quality and safety and reduce harm (Ministry of Health, 2016).

Question 1:

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback (MSF) and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Evidence suggests that peer review and MSF contribute to improved doctor performance therefore it is important that these tools be considered when developing an individual's PDP; however the RANZCP position is not to include MSF as a mandatory component of CPD in the current programme due to the difficulties in administering the tool for our Fellows in private and/or solo practice.

We argue that the purpose of the PDP must be clear – if it is purely used as a vehicle to identify future learning needs than it is not meeting its entire function. Some peer review group sessions might provide the doctor with an opportunity to 'keep- up-to-date' with current clinical practice rather than developing new skills or identifying gaps in practice. We suggest the PDP is kept broad in application so doctors can use it to guide them towards those areas where they may wish to keep informed **and** it should also include aspirational elements so the doctor can strive towards developing new skills. In essence there are four key elements to a PDP cycle: think, plan, do and review. The RANZCP has developed a range of supporting materials to guide our members through the PDP process[1] (RANZCP, 2011).

We accept that analysing individual outcome data is beneficial in improving a doctor's performance. Doctors practising in procedural specialities have access to clinical registries and clinical audit data that provides a meta-analysis of patient outcomes, thus allowing the individual doctor to compare their outcomes against their colleagues practising in similar circumstances. Clinical registries and audits have made a significant contribution to improving health care, identifying best practice and providing benchmarking data so individuals can improve their practice over time based on tracking their own data (Horque, 2016).Outcome data of this nature could be readily accessed and included as an objective within the individual's PDP.

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[1] We have developed a specific document – 'Developing a Professional Development Plan' which is only available for members on our website.

Psychiatrists do not have access to data sets where a meta-analysis is undertaken of nation-wide patient outcomes. The individual prescribing data collected by PHARMAC may provide an opportunity for a psychiatrist to analyse their individual prescribing behaviour against other practitioners. This information could be used to inform the PDP to improve prescribing behaviours amongst psychiatrists.

The role for Colleges would be to inform their members of any possible sources of national or regional outcome data that may assist medical practitioners with benchmarking activities and practice improvement. The links to these data repositories, along with background information about the organisation's data collection, could be posted within a College CPD programme. We argue it would be the responsibility of the individual doctor if he/she wished to utilise these data.

We note that the analysis of outcome data is but one contributor to the doctor's professional practice. The RANZCP, along with many other Medical Colleges, subscribes to the CanMeds competency –based model that describes the range of professional attributes that a doctor must demonstrate competently in order to deliver high quality care (RANZCP,2012; RANZCP 2013).

CPD activities, and the PDP, must embody all the key elements that make a doctor competent in his/her practice therefore we would want a strengthened recertification programme to also place some emphasis on communicating, advocacy, managing, collaborating and scholarly endeavours alongside clinical expertise.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

We support the proposal to ensure each doctor completes a PDP. The RANZCP contends that planning for CPD is an integral component of the CPD activities and should be undertaken on a yearly basis (RANZCP, 2017).

The RANZCP's CPD programme includes a PDP component and we encourage our members to use this tool to develop targeted CPD goals that relate to their area of practice. We would also encourage the individual doctor to review their plan with a colleague to check their progression against the plan and to review the relevancy of the PDP to their current clinical practice, role (within the service e.g. management and leadership roles), patient mix and environmental context.

Question 3:

What is your view of medical colleges defining knowledge requirements for their vocational scope of practice and incorporating these into their recertification programmes?

Knowledge requirements being MCNZ's statements, Good medical practice, cultural competence and the Code.

The RANZCP understands that the focus of this question is upon developing knowledge requirements around professional practice rather than clinical practice. A recent report published by the Health and Disability Commissioner noted that many patients complained about the doctor's professional conduct e.g. disrespectful manner /attitude, failure to communicate openly/ honestly with patient and/ or family/ whanau (HDC, 2016). This information points to a need for doctors to improve their professional skills alongside their clinical expertise.

We argue that including knowledge requirements, as outlined in Question 3, will lead to improved patient care and possibly fewer complaints being received by the Commissioner. The MCNZ's *Good Medical Practice* and the supporting practice statements set the professional standards for doctors practising in New Zealand and many doctors are not aware that these statements have the line included "*may be used by the Health Practitioners Disciplinary Tribunal, the Council, and the Health and Disability Commissioner as a standard by which your conduct is measured*"

We believe many doctors are not familiar with these documents therefore some method of disseminating this information has to be considered. We understand that Bpac[2] has successfully implemented, into their general registrant CPD programme, a short online test where individuals answer a number of questions pertaining to the various MCNZ statements. This activity would remind doctors of the current standards, alert them to any changes to the standards and also provide a range of resources linked to each statement. It would not be difficult for the MCNZ to devise a short test that could be used for vocationally registered doctors.

Cultural competence should be firmly embedded in all college's recertification programmes. We support the inclusion of cultural competence as this would align with MCNZ's accreditation standards as outlined in '*Additional criteria for assessment of Specialist Medical Training and Recertification programmes'*.

We also note that under section 118 of the Act responsible authorities are required to set standards relating to cultural competency.

Evidence indicates that cultural competence can contribute towards reducing the persistent health disparities currently experienced by Māori (Bacal, 2006). We argue that cultural competence needs to be demonstrated in each individual doctors CPD programme and that the MCNZ could provide some guidance regarding possible activities that would meet cultural competence requirements e.g. feedback from Māori patients, undertaking a course in Te Reo, visiting and observing a Māori health provider.

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[2] Bpac has designed a short online essentials test that rotates a number of "knowledge " question around the MCNZ statements. This CPD programme is designed for general registrants but a similar test could be developed for vocationally registered doctors.

Question 4:

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide Regular Practice Review as an option for doctors within their recertification?

The RANZCP's CPD program already has a Practice Development & Review component. Historically not a great number of psychiatrists have participated in Practice Review and we acknowledge that greater promotion of this CPD activity is required amongst the New Zealand members.

We support RPR but are aware that other activities such as workplace appraisals may have similar components to a RPR therefore there needs to be a streamlined approach whereby RPR, appraisals and credentialing activities are not duplicated. The CMC's '*A Best Practice Guide for Continuous Improvement'* addresses this issue in some detail as potentially there could be higher compliance costs for doctors if multiple activities are undertaken collecting overlapping data.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The RANZCP notes that employers also have a responsibility to support their employees in developing their individual development needs. The RANZCP would be able to direct the employer to useful resources to support the psychiatrists learning needs such as practice guidelines and our online e-learning platform –Learnit.

We strongly believe that it would be the responsibility of the psychiatrist to approach the College if they required additional support. The RANZCP has developed a comprehensive range of resources that could be packaged to meet each doctor's needs. We believe the Colleges do have a role in providing individual guidance to those doctors who have identified an area where they require additional knowledge and skills.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

The RANZCP does not support mandating particular CPD activities for older doctors.

We believe mandating specific CPD activities for older doctors will not sit well with the Human Rights Act 1993 that prohibits discrimination based on a person's age and the Human Rights Commissioner who is encouraging employers to employ older people and develop a culture where older people are valued (HRC 2015).

As psychiatrists we work closely with individuals who experience cognitive decline and we note that people's cognitive skills may decline at different chronological ages. For example early onset of dementia may occur in some individual's in their late 50s therefore we contend it is difficult to say categorically at what particular age a doctor would need to be directed

towards specific CPD activities. We also question who would be responsible for assessing those doctors who may present with declining cognitive skills as assessing and managing these individuals requires expert training in the field of psychological medicine. We also note that specific guidelines for the ageing doctor would need to be based on a doctor's medical specialty. For example, a plastic surgeon requires greater level of motor-eye co-ordination than a public health physician so the question remains how these issues would be managed across the various vocational scopes.

If the MCNZ is seeking to identify at risk doctors and direct them towards particular CPD activities then we suggest they focus on those doctors who work in isolation and those who are '"*frequent flyer" doctors who attract a disproportionate share of complaints'* (Paterson, 2013).

Studies in Australia have noted that 3% of all doctors accounted for 49% of all complaints therefore it suggests that a small group of doctors are responsible for poor outcomes (Bismark, 2013).Paterson notes 'there *is clearly a need to do so in this context. Indeed, the fact repeat offenders can continue unchecked indicates a failure of colleagues, employers and regulators to respond satisfactorily—a different kind of 'system' problem'* (Paterson, 2013). In order to protect the public and reduce harm, which are the key underlying principles of the Health Practitioners Competence and Assurance Act 2003, it would be a useful investment of resources to concentrate on improving the practice of the "frequent flyer" doctor. Targeting these doctors and developing specific CPD activities for this group may contribute to greater improvements in quality of care.

We would advocate for a greater emphasis on working more closely with those practitioners who practice in geographical or professional isolation as it is often difficult for these doctors to participate in CPD activities such as peer review groups due to their geographical location and/ work commitments. The Royal College of Physicians has outlined clearly the challenges facing the isolated practitioner in the New Zealand situation (RACP, 2015). The RANZCP has developed a comprehensive online platform, Learn*it*, that allows isolated doctors to access a range of resources including podcasts and e-learning modules but there must still be some opportunities for those practicing in isolation to work with and meet with their colleagues in a face-to-face or a one-on-one situation. The paper produced by CMC placed particular emphasis on the doctor having 'the structured conversation' with a peer to obtain objective feedback on their practice. We believe doctors working in isolation must not be disadvantaged in accessing CPD and should be provided with additional support from their Colleges and MCNZ.

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The RANZCP understands that the focus of this question is to ensure that Colleges regularly review and adjust their CPD program so it is 'fit for purpose' in a general sense e.g. it meets the regulators requirements and best practice approaches are implemented.

We review our CPD programme from time-to-time to ensure new methodologies and research are included in the programme e.g. we are currently reviewing our practice visit component based on research and information based on other medical colleges' experiences.

Quality improvement activities also include developing new ways to improve our members' interaction with our CPD programme e.g. we recently developed a new e-learning platform, Learn*it*, providing members with access to hundreds of learning activities including modules, podcasts, videos and webinars in one convenient location.

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

We have no additional comments to make regarding the *Vision and Principles for Recertification* as we outlined our position in our earlier submission.

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

We do not see any challenges to implementing the proposed recertification changes as we have already developed many of the components suggested in this latest MCNZ document. The knowledge requirements outlined in question 3 require further discussion as we would see the MCNZ working with the Colleges to implement a streamlined methodology for upskilling doctors around the MCNZ statements.

Developing and implementing the recertification elements will be resource intensive for those colleges who currently do not have these components within their CPD programmes.

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Three years may not be an appropriate transition period as some College's will need longer if they are to develop a robust Regular Practice Review component within their CPD programmes. The RPR process is a particularly time consuming activity requiring significant resources and it may not be possible to develop and implement a system within three years.

Additional Comments

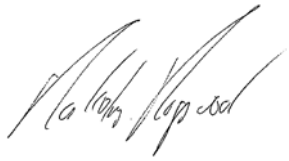
We would argue that CPD activities need to include some reference to the doctor's health and identification of those CPD activities that might contribute to addressing potential challenges in a doctor's practice e.g. how is an individual ameliorating the possibility of professional burnout. A recent survey noted that a high proportion of senior doctors are experiencing burnout and evidence suggests a strong association between burnout and poor clinical outcomes (ASMS, 2016). The General Medical Council has specially included

information regarding the individual doctor's health status in their revalidation process and we suggest that the MCNZ could investigate how doctors' health might be addressed with a CPD activity. (CMC 2013)

The RANZCP is aware that CPD is one of the many activities that a doctor, particularly in public practice, may undertake to ensure their knowledge and skills are relevant to their scope of practice. It is critical to ensure that credentialing, individual work place appraisals, registry and clinical audit activities, and CPD activities are not duplicating efforts and resources. The document developed by Council of Medical Colleges (CMC, 2015) sought to draw these various activities together, providing guidance on how to integrate these activities to inform the doctor's practice. This is an issue requiring further discussion across the sector involving Colleges, MCNZ, The Ministry of Health and the employers.

Thank you for the opportunity to provide feedback. If you require further information regarding this submission, please contact the RANZCP's New Zealand National Manager, Ms Rosemary Matthews who supports the New Zealand National Committee – Tu Te Akaaka Roa. Rosemary can be contacted on 04 472 7265 or email Rosemary.Matthews@ranzcp.org

Yours sincerely



Professor Malcolm Hopwood
President

Ref: 0651o

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Strengthening recertification for vocationally registered doctors

CONSULTATION FEEDBACK

Please complete the feedback form and return via email to: **recertificationconsultation@mcnz.org.nz**

Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: ☐ Individual ☑ Group

Name: **Helen Morgan-Banda**

Position/title: **Chief Executive**

Organisation: **The Royal New Zealand College of General Practitioners**

Do you agree to your submission, or parts of your submission being published: ☑ Yes ☐ No

Do you agree to all or parts of your submission being published if it was anonymised: ☑ Yes ☐ No

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

20 March 2017

Our ref: HMB17-224

Karen Davis
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Medical Council of New Zealand
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Wellington 6143

Email: recertificationconsultation@mcnz.org.nz

Dear Karen

Consultation on strengthening recertification for vocationally registered doctors

Thank you for the opportunity to provide feedback on the Medical Council of New Zealand's (the Council's) consultation on strengthening recertification for vocationally registered doctors. This work will have important implications for The Royal New Zealand College of General Practitioners (the College) and College members.

Executive summary

- The College is committed to improving its continuing professional development (CPD) programme to promote patient safety, better patient outcomes and practice improvement.
- Member feedback has formed the basis of this response and will continue to inform the College's direction of travel towards an improved CPD programme.
- The College supports the principles for recertification put forward by the Council in 2016. However, we are concerned that the proposal in this consultation document goes considerably beyond a principle-based approach. The requirements in the proposal are presented in a prescriptive manner which suggest that little flexibility, if any, will be allowed in interpretation. We are not clear whether this is the Council's intention and ask that this be clarified and flexibility incorporated where possible.
- The consultation paper does not make a clear distinction between the role of the Council as a regulator and the role of the College as an educational institution. It appears that the Council is devolving its responsibility as a regulator to the medical colleges. We suggest including the Council's role in recertification in the final document.
- The College's 2016 workforce survey showed that 22 percent of general practitioners (GPs) feel burnt-out. Our members are already under a large compliance burden, involving achievement of health targets, Primary Health Organisation (PHO) reporting, and practice accreditation processes and mandatory requirements. It is important that any new recertification requirements are not overly onerous, are simple to achieve and do not increase administrative or compliance loads. College members have indicated the potential for the requirements to drive GPs into early retirement. We are concerned that a major change to the programme could be the tipping point for the current critical workforce shortages in general practice.

- We are concerned that the evidence-base for proposals made in the document has not been presented. Where these proposals are far-reaching, this evidence is surely crucial. In particular, we consider that a full literature review should be included for the use and value of the professional development plan (PDP) in post-qualification continuing development programmes for professionals, the value of an annual conversation as a form of peer review, the value of the regular practice review (RPR) process in different scopes and contexts, and the basis for, and effects of, age differentiation.

- We ask the Council to note that the general practice context is significantly different from that of other medical specialties which are more procedural-focussed and/or based in a hospital context. Some elements of the proposal, if applied prescriptively, would not fit well in the general practice context.

- We are concerned about the level of resourcing (financial, workforce and time) that would be required to implement this proposal in its entirety.

- We are not sure what is intended by the reference to **qualitative** performance and outcome data. The language of the document and the specific measures suggested seems to favour quantitative measures. We ask the Council to note that quantitative measures are not easy to capture in general practice and are not widely available at the national level. In addition, we caution that an overreliance on quantitative measures may not lead to improvements in the quality of what is measured. If qualitative measures are what is intended, we suggest that the language of the document is amended to reflect this.

- We note that the proposal appears to be a move away from a system that is time based (ie sets minimum hours to be spent on activities each year). It would be useful if this was explicitly confirmed in the document.

- With regard to specific proposals in the document:

  – The College supports the ongoing use of audit of medical practice as a CPD programme requirement. However, we are not convinced of the value of, and are not ready to implement, any form of audit which relies on a national database of individual practitioner performance and outcome results. If this is what is required, considerable resources and planning would be needed.

  – The College's experience is that the multisource feedback (MSF) tool is valuable only in identifying outliers and not in providing data which will better inform members' professional development planning. We believe that MSF should remain optional in the recertification programme.

  – The College recognises the value of developmental and supportive collegial review. However, we would not support the creation of a process of annual external review with a regulatory function. We believe that flexibility needs to be built around the requirement for an 'annual structured conversation with a designated senior colleague'. Achievement of this requirement in its proposed form would not be easy within the context of general practice.

  – The College's experience with the PDP tool which is currently in use by our College has not been favourable. Although some members do find this tool valuable, the majority do not. However, it is possible that, in a new format, the tool could be more useful.

  – The College agrees that the medical colleges are the appropriate bodies for determining the knowledge requirements for their vocational scope. However, we point out that these requirements cannot be used in a 'tick box' sense to determine a 'standard of practice' in each curriculum area or for any possible presentation.

- We do not have any concerns about a requirement for RPR to be an option on recertification programmes. However, we point out that this may not be an appropriate tool in all contexts.
- The College agrees that providing additional and collegial support for its members is an important part of its function. However, we would be concerned if the Council is suggesting that the colleges bear responsibility for identifying those at risk and for putting in place remediation programmes in these instances.
- Our members do not support Council mandating specific requirements as doctors age, and the College is concerned that this may precipitate early retirement. We believe that the College has an important role to play in enabling and supporting older doctors who wish to stay in practice. This may include providing general guidance on strategies that can be used to self-regulate and to mitigate possible age-related risks. Beyond the provision of general guidance, however, the College is not convinced that individual career planning is an appropriate component of a recertification programme.
- The College agrees that a focus on continuing quality improvement is important and that colleges have a responsibility to ensure ongoing evaluation and review of their programmes.
- We do not agree that Council should be informed of the outcomes of RPR visits for all doctors. Council should be advised only in cases where substantial concerns have been identified.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end of life; and with the most inseparable intertwining of the biomedical and the psychosocial. GPs treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the College, is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- a greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- improved integration of primary, community, and secondary care health and social services which ensures the provision of high-quality services.

- universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- a review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

The Council's consultation

The Council is reviewing the current recertification requirements for vocationally registered doctors and is proposing new requirements and standards for the accreditation of medical colleges, which align with the Council's *Vision and Principles for Recertification*.

The Council's vision is that "Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support continuing improvement in performance." The principles, adopted following consultation in 2016, are that quality recertification activities should be:

- evidence based
- formative in nature
- informed by relevant data
- based in the doctor's actual work and workplace setting
- profession-led
- informed by public input and referenced to the Code of Consumers' Rights
- supported by employers.

The Council has explained that it has traditionally regarded CPD as the key mechanism for recertification. The Council now proposes new requirements to ensure the effectiveness of CPD on performance. The Council states that CPD is more effective when linked to baseline performance and when it addresses an individual doctor's learning needs. Further, that recertification programmes and activities should provide quality assurance and should support continuing improvement in performance.

The College's feedback

The College is committed to the development of a CPD programme which ensures the continuing competence of vocationally registered doctors and places high-quality equitable health outcomes and patient safety at the core. We are pleased to have the opportunity to work with the Council on developing the appropriate requirements for ensuring the continuing competence of doctors.

The Council will be aware that we have already been giving consideration to the College's CPD programme to ensure it is fit for purpose and aligned with the current understanding of best practice. We regularly survey our membership for feedback on programme requirements, most recently in 2016 when we received over 1500 responses. In January 2017, we notified College members of the Council's proposed recertification and invited feedback via a survey or directly to College staff. We received over 360 responses. This feedback has been valuable and will help to inform the College's direction of travel.

However, to better understand how the College's CPD programme can better meet the needs of our members while satisfying Council's set requirements, we intend to further engage with our members, PHOs and other relevant parties. We consider this engagement and our members' voice to be critical for the development of the College's CPD programme. We welcome the opportunity to work closely with the Council to ensure any proposed changes will meet the Council's requirements.

General comments

Principles-based approach

In 2016, the College supported the adoption of the Council's new principles for recertification programmes. Our understanding was that it would be the responsibility of the medical colleges to account for the manner in which their CPD programmes meet these criteria. At a meeting held on 20 February 2017 with College staff and in subsequent correspondence, the Council has confirmed that it is the Council's responsibility to establish a set of high-level principles, and that the content of the specific CPD programmes should be determined by the medical colleges as the 'subject matter experts'.

However, the College's view is that the current proposal goes considerably beyond the principles-based approach in terms of:

- setting additional requirements and responsibilities for colleges which may require considerable resourcing, place colleges in a difficult relationship with their members, and open colleges to the risk of legal action in cases where an individual member may have transgressed.
- setting specific requirements for the activities which must be included in recertification programmes.

We note that the language used throughout the document suggests that the requirements should be read prescriptively. It is not clear whether the prescriptive approach was the Council's intention, or whether there will be some flexibility allowed in interpretation. We suggest that if prescription is not the intent, the document is redrafted to show where flexibility may be applied. This applies throughout the document, but as an example, the document includes the requirement for the 'structured annual conversation with an external peer' as a 'minimum each year'. Does that annual minimum apply in all cases, or only in cases where other forms of external peer review are not operating?

It would be useful if the section in the document, 'Doctors registered in a vocational scope of practice' included a statement outlining the extent to which medical colleges are responsible for defining the recertification requirements in their scopes.

Role of the Council versus role of the College

The College draws the Council's attention to the differing roles played by the Council and the College. The Council's principal role as a regulator is to protect the health and safety of members of the public by determining who may practise medicine in New Zealand, and the conditions or requirements that pertain to this practice. Conversely, the College is a professional body and educational institute. As a professional body, the College's role is to represent member interests and advocate on their behalf. As an educational institution, the College provides programmes which enable specialisation and ongoing development in the scope of general practice.

The consultation paper does not make a clear distinction between these roles, and could be read to imply that the Council is devolving its responsibility of regulation to the medical colleges. We stress that the College does not have the same regulatory relationship with its members as the Council does, and cannot, nor wants to, act as a surrogate regulatory body.

The College understands that the proposal presented reflects a change of philosophy, from an understanding that participation in development and quality improvement activities can act as a proxy for competence, to a model where this competence must be assured (at a basic level through the tools suggested) in addition to requirements for participation in ongoing development and quality improvement activities.

We recognise that the Council wishes colleges to play a greater role in proactive identification and support of at-risk practitioners. However, the College considers that, while we do have a role in quality promotion, we are not a regulator. We are constrained in the actions we can take to assess members' 'risk' and to intervene

in individual cases. This is particularly the case since doctors, should they choose to do so, are able to withdraw from membership and practise within a general scope of practice. In addition, it is our view that more consideration is needed on the risks and legal ramifications associated with any transfer of responsibility for proactively identifying members 'at-risk' from the Council to the colleges.

The Council is uniquely placed to regulate recertification. We suggest that its role in this regard be made clear in the final document.

General practice workforce and burn-out

The College urges the Council to ensure that new recertification requirements are not more onerous than the current requirements.

There is currently a shortage of GPs across New Zealand, particularly in rural areas. This shortage is anticipated to grow over the next decade. We draw the Council's attention to the College's report, **Work & Wellbeing: Workforce Survey 2016**, which is attached as an Appendix and available on the College's website.

In particular, on page 17, the survey showed that 22 percent of GPs feel 'burnt-out' (n=1820): only 36 percent of respondents agreed that they usually had enough time to complete all their daily tasks (page 14 of the report).[1] The compliance burden arising from existing reporting requirements (national health targets, PHO reporting, and mandatory practice accreditation processes) is already very high. Member opinion is that the recertification requirements are also already onerous (taking personal time and funding) and concerns have been raised about increasing this burden of compliance.

The College takes these concerns seriously:

- An overly onerous recertification programme may be the tipping point that drives GPs into early retirement and exacerbates the looming critical workforce shortage in general practice.
- The more stringent requirements become, the more difficult it is for GPs to continue to provide services independently of the larger practices or employer organisations. This has implications for the provision of care, particularly in rural regions.
- Any changes to the programme which are perceived to be onerous could have implications for the relations the College has with members. Members have commented that they could opt to practise within a general scope of practice rather than maintain their Fellowship with the College. There could be long-term risks both to the College and to the quality of services provided in the sector if the proportion of non-vocationally registered doctors increased.
- An increase in compliance activities which are not directly related to improved patient care might have implications for the quality of the care provided.

Our members are already doing a huge amount with limited resources. Their CPD programme needs to be seen as a valuable contribution towards their professional development and to the quality of their practice. Excessive focus in recertification programmes on issues that serve a basic quality assurance function and are not a useful function for the vast majority of doctors is a poor use of resource. We stress the importance of finding a solution that does not over-burden doctors in its quest to ensure patient safety.

1 The Royal New Zealand College of General Practitioners. Work and Wellbeing: Workforce Survey 2016. Wellington: The Royal New Zealand College of General Practitioners; 2016.

We highlight some of the comments made by College members:

"I'm dismayed at the thought of more paperwork and likely higher compliance costs, which in general practice are ultimately passed on to patients, eg practice visits will cost money."

"If the process becomes too prescriptive or expensive, then it will undermine the College's current attempts to increase the general practice workforce and may force some excellent doctors into early retirement."

"These proposals are just more time consuming, draconian 'box ticking' exercises! Doubt very much that it will make for 'better doctors', but will probably drive some more experienced GPs out of practice"

"There is a fear and warning that older rural practitioners will get fed up with accreditation compliance and that this will contribute to a loss of staff in the sector that has a need to retain doctors."

"General practice is becoming more and more audit, performance data and guidelines driven. More and more time in the consulting day is spent staring at computers entering data and less time actually engaging with the person/patient. Continuing education should be driven by one's passion for medicine, the desire to be a better GP, to be stimulated by educating ourselves further in our particular interest and thus better serve our patients. The job is already stressful, additional auditing, performance reviews, peer reviews, endless hoops to jump through each year is yet another added stress. CPD is becoming more of an exhausting 'tick box' activity – I am not sure this equates to safer, better performing doctors."

"I think this is an intrusive and excessive attempt to control the practice of GPs in New Zealand and will lead to an exodus from the profession. I worked extremely hard to achieve Fellowship and I now feel like this is an enormous setback, the threat of constant pressure and surveillance and assessments when I have better things to do like trying to manage my 1500 patients. I can envisage GPs failing to perform their clinical duties because they have so many recertification tasks to complete."

"Making the whole process more arduous will be a negative for general practice. Also if more pressure is placed on 'ageing' GPs it may lead to more GPs opting out of or reducing their time in general practice which is not ideal considering we are supposed to be approaching a manpower crisis."

"We need to be mindful that we cannot expect GPs to do all of this stuff in their personal time. The whole business of 'self-care' is at stake here."

"I am not convinced data is accurate enough to inform learning needs."

Evidence-based approach

If the premise for the proposal is that an evidence-based approach to CPD activities improves performance, then the evidence for this proposal should be presented. We note the paucity of supporting evidence provided, and that full literature reviews, including recent evidence, are not cited. An evidence-based profession needs to be assured that the evidence behind the effectiveness of the proposal changes is robust.

In particular, we believe the full evidence base should be presented regarding the value of the professional development plan in post-qualification continuing development programmes for professionals, the value of an annual 'structured conversation', the value of the RPR process and the basis for and effects of age differentiation.

Context of general practice

The nature and context of general practice differs substantially from that of medical specialties which are procedural-focussed and/or based in a hospital context. Not all of the requirements within the proposal fit well within this context.

Differences include:

- The clinical scope of general practice is exceptionally broad. There is no simple procedural list that can be generated and against which specific audits can be created that would encompass this breadth.
- A key element of general practice is good communication in the context of a consultation. The fluid nature of this interaction is less amenable to quantitative measurement than is the case for procedural interventions.
- With the exception of prescribing data, there are currently no centralised datasets relating to the performance or outcomes of the individual practitioner in general practice.
- Collaboration and integration in primary care are important to achieving good patient outcomes. However, much of the clinical engagement in general practice happens in individual consultation 'behind closed doors'. There is the potential for practitioners to become isolated from peers even when situated in large practices. This is different from most hospital-based scopes. There is much higher value to be gained in general practice from initiatives that place emphasis on consultation review and discussion than in scopes where the 'consultation' is already team based and clinical decisions are taken in multidisciplinary meetings.
- Unlike doctors practising in secondary care, in many cases in general practice, the practice is owned by the doctors themselves. Except in the largest practices, there are often no clinical governance structures or clinical director positions within the practices themselves. Annual performance appraisal processes (as part of employment agreements) may not be used. This means that the requirements for an annual 'structured conversation with a designated senior colleague' could not be easily linked to existing processes.
- GPs are generally paid for clinical time only, with no funding provided for CPD activities, and no payment for the time spent achieving them. The cost to College members for participating in additional activities in terms of the financial cost and of time away from clinical practice must be taken into account. It is important to our members that a new recertification programme should not further disadvantage them. The implications of changes for small rural practices in particular should be given due consideration.
- The requirements for practice accreditation in general practice include compliance with minimum legal, regulatory and professional and standards. Responsibility for meeting these requirements falls largely onto individual practitioners. In a large hospital, this function would not typically be undertaken by clinicians. This results in a higher compliance burden in general practice.
- General practice varies in terms of clinical areas of focus, physical location (including remote practices and time spent internationally) and hours spent in practice (with a high proportion of doctors in locum positions). In addition, not all GPs are involved in providing clinical care to patients. Recertification requirements must be sufficiently flexible to cater for this breadth.
- The number of vocationally registered GPs is very high compared to the numbers in other scopes, and GPs are geographically very dispersed. This increases the costs of any proposed interventions, which may impact on rural, high-needs and Māori/Pasifika medical delivery.

Resourcing

The College's current CPD programme meets some of the Council's proposed requirements.

We use annual PDPs, which must be discussed with a colleague (this could be regarded as a reduced version of the proposed annual 'structured conversation'). RPR is provided on an optional basis. The College makes available CPD opportunities for members by means of providing access to a reputable international online learning system, by endorsing local providers and events and by providing a national conference and regional Faculty events for this purpose. An annual audit of medical practice is required, and the College provides a small number of self-audit templates as well as endorsing tools provided by other organisations for this purpose. The College encourages self-directed planned learning and reflection on learning activities. The College also provides an online facility for members to record their CPD activities, and monitors all members' compliance with CPD requirements.

However, under the proposal, it appears that the College's role would need to significantly increase. This includes the need to take responsibility "for assisting doctors to use performance and outcome data to identify professional development needs". We accept that the College should assist members to use this data to identify learning needs. However, we are concerned if it is the Council's intention that the College actively provides and monitors this outcome and performance data. Given that data is not readily available in general practice for this purpose, it would not be easy to comply with this requirement. Any development in this area would require considerable resourcing.

The College's role would also need to expand to include providing additional support for identified sets of doctors, and "supporting doctors to implement their PDPs". This seems to be a large step from the current situation where it is the doctor's professional responsibility to ensure that they undertake activities (which the College may have recommended, endorsed or provided) that will enable them to meet their PDP goals. We are unsure whether the College can provide individualised support for all doctors in this manner, and would not be able to do so without considerable investment of resources and possible costs to members.

RPR is expensive in the general practice context. CPD activities and time spent (in review or as reviewer) are not reimbursed by employers. If this initiative is expanded, there would be financial implications for our members. If the College is additionally required to have a nationwide set of 'designated senior colleagues' to provide external peer review for all members on an annual basis, costs to members (either directly or indirectly as a result of lost clinical time) will be large.

Outcomes and performance data

We find the language used in the proposal with regard to outcomes and performance data contradictory and confusing. Although the document refers to **qualitative** performance and outcomes data, the use of the term 'outcomes and performance data', as well as the specific measures given, suggest a more quantitative interpretation.

If the performance measures referred to are intended to be **qualitative**, we would suggest that the document be amended to refer to 'feedback on performance and outcomes'.

If the reference is, as it appears, to a more quantitative understanding of performance data, we note (as mentioned above) the difference between general practice and more procedural specialities. Performance and outcomes in general practice are not easy to measure or capture through quantitative data, and data at the level of the individual practitioner is not easily available.

In the latter case, we caution that:

- This will lead to a system which leans towards matters which are easy to measure, rather than those that may have a more substantial impact on quality. Overuse of the MSF tool is one such example.
- Care must always be used in the interpretation of data, since practice contexts and patient populations differ widely. Blanket comparisons of data, without reflection on the reasons that differences may exist, are not valuable.
- This may lead to additional compliance costs both directly to the practitioner and in terms of time required to be spent.

We recommend that the Council amend the document to make this requirement clear.

Recognised CPD

The proposal appears to be a move away from a system that is time based (ie sets minimum hours to be spent on activities each year). It would be useful if this was explicitly confirmed in the document: Will there be no specific time-based requirements set for the amount of CPD that must be attained in a year? The College would support this particular move. However, our members would not support a system where the new requirements are added to existing requirements. The implications for ensuring consistency between doctors and between CPD programmes would need to be considered.

The proposal does not specify the types of CPD that can be used to attain PDP goals. In the past, there have been suggestions that there is insufficient evidence on the value of activities such as conference attendance to justify their inclusion in recertification programmes. We do not see value in refusing to recognise these activities. Particularly in scopes where there is a risk of isolation, the value of opportunities to develop collegial and inter-professional links is high. These activities also present opportunities to hear about developments in areas that might not be of immediate clinical relevance (or captured in a pre-determined PDP) but which can lead to further educational activities or to the development of areas of interest. We note also that individual learning styles differ, and while participative activities may suit the majority, there are those for whom didactic sessions, appropriately reflected upon, are the best way to learn.

The College requests clarity

This proposal, and its apparent lack of flexibility, has led to questions and unease amongst our membership. The College strongly recommends that the Council take into account the feedback received and revise the proposal, ensuring that clarity is given on mandatory requirements and those that are more flexible, and provide a clear account of what is required or expected if they differ from current requirements.

Our response to the Council's questions

Set out below is the College's feedback to the specific questions raised in the consultation document.

Question 1

Proposal: Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

The College's current CPD programme includes some activities (eg audits of medical practice, the RPR process, some peer review activities) that provide doctors with feedback on their practice, and which can be used to further direct doctors' learning. While the College agrees that recertification programmes should include some evidence of feedback on individual performance in recertification requirements, we would caution against placing too much emphasis on data measurement.

As noted in our general comments, we believe such a recertification model risks stressing activities that are easy to measure, rather than those activities which are meaningful for the doctor's professional development or which encourage significant improvements in practice.

We also note that outcome data for individual practitioners in the form of quantitative datasets are not easily available, that there is no national consistency in data and that results can be subject to misinterpretation.

We asked College members if they agreed that recertification activities should be based on doctors' performance and outcome data. Overall, of 354 respondents, 49 percent disagreed with the proposal of using performance and outcome data (including MSF and external peer review) to identify a doctor's professional development needs. Only 26 percent of respondents agreed with this proposal.

Some of the feedback we received is as follows:

> *"Performance and outcome data are difficult to obtain, hard to apply to a very generalist doctor, and hard to analyse for general practice."*

> *"Current measures of outcome are difficult to use and are too blunt and inaccurate to measure true quality."*

> *"Does not take into account socio-economic factors impacting on patient care, mobility of the population and hard to reach communities."*

> *"It is likely to be biased towards measurable targets."*

> *"Outcome data risks driving and skewing behaviour to a tick box exercise of limited value."*

> *"Outcome data advantages doctors working in well-off populations with lots of resources and could have a negative effect on health equity."*

Set out below is specific feedback on using the outcomes from audit, results from MSF and feedback from a review undertaken by external peers in the recertification requirements.

a. Audit

Current Council requirements for CPD include the requirement for an annual audit activity. The Council's definition of an audit of medical practice is "a systematic, critical analysis of the quality of the doctor's own practice that is used to improve clinical care and/or health outcomes or to confirm that current management is consistent with the current available evidence or accepted consensus guidelines". The criteria for conducting an audit of medical practice are specified by the Council.

Currently, GPs fulfil this requirement by undertaking organisational audits approved by the College, or by devising audits relevant to their own practice. We support continuing this requirement. However, we note that:

- This requirement is particularly difficult for locum doctors who do not have access to their own patient base to audit.
- There are many audits that are conducted in general practice that are focussed at organisational or practice level. These do not identify individual practitioner outcomes and are currently recognised for CPD purposes only if combined with individual reflection and development plans.

It would help if the Council clarifies whether anything further than this is intended in the new proposal. One reading of the document is that a specific audit tool (or tools) must be created by colleges against which doctor performance is monitored. Whilst this may be possible in more procedural scopes (with specific outcome expectations set for specific procedures), it would be difficult to adopt such an approach in general practice, where the range of potential audit topics is broad, where outcomes are not easy to measure, and where patient presentations are complex and often unique.

The College is not currently involved in data collection, either for the existing audits undertaken by doctors, or of health system data which would enable national audits to be created (although there are instances where specific PHOs are able to provide this level of data to their doctors). The only data available nationally to all members (although not directly to the College) are the prescription reports currently produced by bpac^{nz} (the results of which need contextual interpretation). If this is what the Council has in mind, this area would need considerable development by the College.

We note again that the range of general practice knowledge is very broad and largely non-procedural. We note that it is unlikely that tools could be developed that would be sufficiently comprehensive to identify all possible skill areas and content areas for updating.

b. Multisource feedback

The College has, for more than 20 years, offered a patient satisfaction tool for practitioner use and has recommended a colleague feedback survey available internationally. These tools are compulsory within the training programme, and are optional for Fellows on the CPD programme. A patient survey is also required three-yearly in the *Aiming for Excellence* accreditation processes for general practices. In 2016, the College piloted a new version of MSF based on the General Medical Council tool (as recommended by the Council). This tool has unfortunately proved to be too administratively intensive for a large-scale roll out.

Our experience, based on analysis of data and feedback on these tools, is that, whilst they are useful to identify doctors whose practice is considerably below the norm, results tend to cluster at the very high end of the scale (with a very high majority of doctors attaining ratings of 94 percent and above). Thus, results are non-discriminatory. In addition, the simplicity of the questions asked does not, on the whole, allow for the identification of specific areas to inform professional development planning. The value of the tool lies in its ability to identify outliers and not (except when used as part of a structured training programme) in its ability to enrich professional development.

Specifically with regard to the use of the colleague feedback tool, the College is concerned that:

- There is potential for adverse consequences on collegiality in small regions if negative comments are received.
- Survey fatigue will result if the MSF tool is required to be used regularly by all doctors. In particular, in rural areas and small towns, people are likely to be selected as survey respondents multiple times.
- This tool will also be difficult to use for those doctors working in a non-traditional settings.

We note that there is already a tool for collecting patient experiences in general practice, which will be part of the mandatory Foundation Standard requirements for all general practices (the Patient Experience Survey provided by the Health Quality and Safety Commission). Although this tool does not provide data at the level of the individual practitioner, and therefore is not suitable for CPD purposes, it does ensure that patient feedback on practice is taken into account.

The College believes that the use of MSF tool should remain optional in the recertification programme. Member opinion is strongly against compulsory introduction (48 percent disagree versus 27 percent agree).

c. Peer review

The College's current CPD programme requires the completion of a set number of peer review hours, which is usually met by our members through attendance at peer group meetings at which cases are discussed. Although there may be variation in how peer groups currently function, College members consider their peer groups to be enjoyable, supportive and to contribute positively towards professional development. They find discussion of cases in these groups to be one of the best ways for learning and identifying further learning needs.

It does not appear that College peer review groups would be sufficient to meet the proposed new requirements for 'a review undertaken by an external peer'. We note the value doctors gain by meeting with a group of peers in a supportive environment where they feel safe to raise concerns. In general practice, the peer groups serve a vital function in counteracting isolation and we would not favour changes that may undermine their continuance. (We understand that peer review groups could be continued as an optional or College-required activity, but would be concerned that this requirement, in addition to those proposed by the Council, would be overly onerous for members).

We note the similarity between this proposal and the requirement in the United Kingdom for annual appraisal by an external appraiser. This is a highly regulatory process. If this is what is intended by the proposal, the College is not convinced of the value that such a process would bring: the insight that the external person will have into the doctor's practice (in the absence of a full RPR-type process) will be minimal.

We note again that that there are seldom clinical governance structures or clinical director positions within a general practice, and that annual performance appraisal processes are not common. This means that this requirement could not be easily linked to existing processes. Costs to implement this proposal would be very high, and, if the focus is regulatory rather than developmental, should not be worn by our members, either directly, or in terms of the time that will be required to be spent. Our members have indicated a strong disagreement with this proposal (60 percent disagreed versus 19 percent agreed).

However, the College does recognise the value of developmental and supportive collegial review. As the Council is aware, feedback from the RPR option that the College offers has been very positive. In addition, an annual conversation with a peer (along the lines of the current PDP discussion) or discussion of a reflective learning portfolio and development plans in a peer group may be more palatable to our members.

Question 2

Proposal: Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

The College's current CPD programme has included a requirement for an annual PDP (which must be signed off by a colleague) for the last six years. Our experience with this requirement has not been positive:

- Although some members get value out of use of this tool, the majority do not see value in trying to specify their learning needs for the year at a single point of time. We are aware that many are completing their plans at the end of the year, adapted to reflect the activities they have already undertaken.
- The manner in which the PDP is currently used requires doctors to identify a small number of goals for the year. Specification of goals in this manner is intended to encourage goal achievement (although the effectiveness of this strategy has not been researched in this context). However, the plan does not in any way reflect the vast body of learning that GPs engage in on a daily basis.
- Our members report that they become aware of learning needs on the basis of specific patient presentations. Some use systems such as a discomfort log as a means to organise their thoughts and plan their learning. Others address identified needs immediately through access to online resources. Members have reported that they see the need to log in to a system to specify goals in advance of this learning to be overly bureaucratic and compliance focussed.

We accept that the specific manner in which our current PDP works may not be ideal for its purpose, and that there may be more effective ways of creating PDPs. We also suggest that other means can be found to achieve the same goals. For example, using reflective learning portfolios as a basis for a peer discussion about future learning plans, and using other technological solutions to lower the administrative burden associated with this requirement.

Whilst the College is not strongly averse to continuing the PDP requirement in some form, we have found little evidence to support the use of learning plans for CPD purposes (ie outside of structured qualifications) in complex professional fields, and request that the Council make available the evidence and research on which it bases this proposal.

Comments from College members included:

> *"I do not believe that the proposal takes into consideration the amount of 'ad hoc' learning we undertake on an almost daily basis. In general practice one never knows quite who or what problem is going to walk through the door. Very often I will find myself refreshing my memory about a disease process heard about long ago in Med School or researching a patient's newly made diagnosis. One cannot 'plan' this sort of learning but it is still 'learning' just the same!"*

> *"It is important to reflect on professional development needs, but the current process of writing a PDP is not always useful as needs can change during the year."*

> *"A PDP is surely a personal plan for an individual. If you make it part of recertification you will surely get plans that are written to impress. A plan is not evidence of safety. In many cases a plan may genuinely identify learning needs but if there is a significant deficit that would indicate a significant deficiency I suspect it may not appear in the plan. It may be worked on in private instead."*

"PDPs have made me think on what I want to know. It clarifies my mind. It should not be onerous, ie not more than three or four goals though, or I will continually pick that I want to make an exit plan!"

"For a well-functioning doctor this is an interative process based on day to day needs – not a preplanned schedule of annual expectations. This would have all the value and effectiveness of drunken new year resolutions."

"Where is the evidence for this?"

Question 3

Proposal: Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence, cultural competence, and the Code of Health and Disability Services Consumers' Rights.

What is your view of medical colleges defining knowledge requirements?

The College agrees that the medical colleges are the appropriate bodies for determining the knowledge requirements for their vocational scope.

The knowledge requirements for general practice are currently described in the *Curriculum for General Practice* (the Curriculum). Core competencies are listed in in six domains (which map to the Council's domains), and specific competencies are listed in each of 31 curriculum areas.

Legislative requirements such as the Code of Health and Disability Services Consumers' Rights and other pieces of legislation fundamental to general practice in New Zealand are included in the general practice *Aiming for Excellence* Standard and practice accreditation process. There is already a system of regulation ensuring that these requirements are met in general practice and the College sees little value in repeating compliance requirements.

The Curriculum, with its domains, curriculum areas and core and specific competencies can be used as a means for Fellows to check their knowledge and to provide ideas for areas in which they may wish to upskill.

However, the complexity and breadth of scope described in the Curriculum mean that it cannot be used in a 'tick box' sense to determine a 'standard of practice' in each curriculum area or for any possible presentation. We assume that that is not what the document intends.

Members have commented that they do not understand this paragraph in the proposal, and would not support any kind of regular 'examination' if that is what is intended.

Question 4

Proposal: Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RPR is currently offered as an option within the College CPD programme. Although participant numbers have not been high. Feedback on this process from those who have been involved has been good. Members have indicated that they support this being an option in the programme (44 percent agree versus 22 percent

disagree). However, they point to the logistical difficulties and costs that would be involved in a more widespread adoption of this option.

We would like to draw the Council's attention to the fact that RPR may not be an appropriate tool in all contexts. The pilot that has recently been conducted on an RPR process in our rural hospital medicine division has highlighted that there is much less value to be gained in that context: rural hospital doctors tend to work in open, team-based environments. A visit from an external peer thus provides less benefit than it does in the relative isolation of general practice.

Some of College members' comments were:

> *"I found this a useful process."*
>
> *"Cost is a big factor? Who is going to pay for this?"*
>
> *"Some people might prefer this but it takes doctors away for general practice to assess and would cost so I don't think it should be compulsory. Would be good to assess doctors where there is concern over their performance."*

Question 5

Proposal: Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The College agrees that providing additional and collegial support for its members is an important part of its function. However, we do not believe that it is the College's role, or that the College has the capacity, to assess and identify the professional development needs of individual doctors. We see it as appropriate that we provide a system in which doctors are encouraged to identify their own learning needs and enabled, where possible, to address them. Where necessary, the College can offer specific support to individuals who have requested it, or who have been directed to us through other means (such as Council processes). However, the expectation should not be that a similarly individual approach will be taken to all members. This would be beyond our capacity.

We would be concerned if what is being suggested is that the medical colleges bear legal responsibility for identification of those at risk, and for putting in place remediation programmes in these instances.

College members' feedback included:

> *"It sounds like a good idea but how would you do this? How many members do we have? How would this be administered? Sounds as if the only real outcome would be a great increase in College fees to cover this."*
>
> *"I agree that our College is obliged to assist our profession in any and all ways to ensure that individual practitioners are doing well professionally and personally in our profession. I do not agree, however, that this means it would also be great if all our members had to keep proving that they are current and safe in their practice to this degree."*

Question 6

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

We note Steven Lillis and Eleanor Milligan state: "The best protection for all is not to further stigmatise ageing, but to have a robust and independent process of ensuring ongoing fitness to practice, which requires **doctors of all ages** to demonstrate that they have the requisite 'inherent' skills to practice medicine safely."[2] [emphasis added]

College members have taken strong offence to the suggestion that Council should mandate certain activities as doctors age (62 percent disagree versus 16 percent agree). They have pointed to the fact that age is a prohibited ground for discrimination under section 21(1)(i) of the Human Rights Act 1993. Members suggested that such discrimination would go against the principle of using evidence-based assessment of training and development as a basis for CPD. They have further pointed to the fact that the evidence for such a proposal is not robust.

The College is concerned that a large proportion of its current workforce is in the older brackets and that this section of the workforce is essential to the health system, both in terms of service provision and in the contribution provided to the profession. Additional requirements set for the ageing doctor may encourage doctors in these age brackets to retire early. Given the looming crisis in workforce numbers in general practice, the older cohort of GPs must be retained unless clear evidence is provided that ageing doctors in general practice present a risk of harm to patients.

Since age does not necessarily mean a change in competence on all tasks and for all doctors, there may be better ways of addressing age-related changes than via recertification. The College considers that it has an important role to play in enabling and supporting older doctors who wish to stay in practice. For example, support might include providing information on age-related potential cognitive changes and general guidance on strategies to self-regulate and mitigate risks.

However, because of the lack of evidence of harm and the potential and serious workforce implications, the College is not convinced that this is an appropriate component of a recertification programme.

Comments from College members included:

> "*This is discrimination and I am sure would be in breach of NZ law. The need for certain activities (or not) should be determined by competencies not age. (If we accept that age should determine the need for specific activities, is gender or ethnicity next on the list?)*"

> "*We should offer career management planning to all of us, regardless of age.*"

> "*Discriminatory. Ignores an individual doctor's self-awareness and self-management as they age. Age alone is certainly not a good marker for an individual GPs competence.*"

> "*There is difference between age and competence and the loss of older rural GPs will result in a collapse in primary care services in the regions.*"

2 Lillis S, Milligan E. Ageing Doctors. Australas J Ageing. 2017 Jan 25. doi: 10.1111/ajag.12371.

Question 7

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement.

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The College agrees that a focus on continuing quality improvement is important and that the colleges have a responsibility to ensure ongoing evaluation and review of their programmes. We note, however, that effectiveness, except with regard to levels of participation and engagement, is not easy to define or measure.

Question 8

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Please see our general responses above.

In addition, with regard to paragraph 10(e) in the consultation document, we do not agree that Council should be informed of the outcomes of RPR visits for all doctors. This is not currently the requirement, and will bring a draconian flavour to what, in general practice, is a strongly collegial and developmental activity. It will act as a disincentive for doctors to participate in an optional scheme. However, we do agree that if concerns are identified in the course of an RPR visit, and these concerns are of a substantial nature, that Council should be made aware of the issue. As is currently the case, we would expect Council to instigate its own investigation process in this instance, with RPR reports remaining confidential within the College.

Question 9

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There is currently no requirement that doctors in the general practice CPD programme should base their professional development activities on performance and outcome data. As discussed above, this data is not readily available at the system level in general practice.

It is likely that the resource implications for the College of the introduction any new requirements will be substantial (and will involve development of systems, technology and people). An increased financial burden is not likely to be well received by members.

Member opinion is that CPD requirements are already onerous (taking personal time and funding) and that additional requirements will not necessarily lead to better patient care. Additional bureaucratic requirements will not be welcomed.

Question 10

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

The College believes that time will be needed to develop a CPD programme that meets any new Council requirements, as well as to develop any new tools and resources necessary. Time will also be crucial to consult with our members, and to socialise and implement a new programme. We agree that adequate time must be allowed.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at **policy@rnzcgp.org.nz**.

Yours sincerely

Helen Morgan-Banda
Chief Executive

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

GP
Heart of the community
Kāinga Tupu

Work & Wellbeing

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The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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FOREWORD

One of The Royal New Zealand College of General Practitioners' strategic pillars relates to protecting and enhancing our GP workforce. To ensure New Zealand continues to recruit and retain high-quality GPs, the College needs to understand its members' concerns, needs and career intentions.

To this end, for the past three years, the College has undertaken an annual workforce survey to help us analyse the shape of our current and future workforce. This year, we contracted Research New Zealand to collate and analyse the results on our behalf. The 2016 survey covered issues not explored previously, including attitudes to practice ownership, the use of technology, GP wellbeing and time spent on various activities.

The 1820 valid responses were analysed, and this data has given us insights into these new topics and up-to-date information on crucial issues such as retirement intentions, vacancies and income, which is not collected in any other national survey. This year, we've spread the survey results over five individual reports.

This report, Work and Wellbeing, is the first to be published. It looks at the hours members work (approximately half work part-time) and analyses how their time is spent. As expected, much of a GP's work involves face-to-face consultations, but we also investigated how much time is given to paperwork and after-hours practice. In addition, we asked about the employment and voluntary commitments members have outside of their practice that relate to their expertise as doctors.

Reassuringly, most GPs responded positively when asked how likely it was that they would recommend a career in general practice. The majority of GPs felt motivated and involved in general practice and believed that they had a good work-life balance.

Despite the busyness of our working lives and the daily challenges of caring for a growing (and ageing) population, this report gives me confidence that, across the country, most respondents find being a GP a rewarding speciality. That said, general practice and GPs need to continue to be supported through adequate funding so patients can see them when they need to and we can train the next generation of GPs.

I'd like to thank everyone who participated in this survey. It's a valuable resource that will help us better serve our members.

Dr Tim Malloy

RNZCGP President

INTRODUCTION

There is great variety in New Zealand general practice. Individual general practitioners vary considerably in the hours they work and the number of patients they see. One-half of GPs (49 percent) work part-time in general practice.[1] Female GPs are twice as likely to work part-time as male GPs (63 percent compared with 32 percent).

Two-thirds of GPs have after-hours general practice commitments (66 percent), with 36 percent of all GPs having these commitments as often as every week or every second week.

The term 'part-time' can be misleading when applied to general practitioners, as 42 percent of all GPs report that they also have work or other commitments (outside of their general practice work) that relate to their expertise as a doctor. This includes time spent working for public or private organisations in an advisory or assessor capacity, and lecturing in tertiary education settings, as well as spending time organising or participating in community or cultural activities, meetings or hui (in a health-related capacity).

In general, as well as reporting longer general practice hours and more face-to-face patient consultations in the average week, male GPs report greater after-hours general practice commitments and more time spent on work or other commitments outside general practice than their female counterparts. Working hours also differ by other factors, in particular by age and rurality.

Those GPs who work longer hours are also more likely to report feeling 'burnt-out'. GPs aged 40-64 years, owners/partners and those GPs who work in a practice that currently has a vacancy for a doctor are all also more likely to report feeling 'burnt-out'.

Overall, 22 percent of survey respondents self-reported as being 'burnt-out'. 'Burn-out' is associated with poorer self-reported health status, as well as less propensity to continue to work in general practice.

This year's survey also investigated GPs' general attitudes towards general practice. It is reassuring to find that most GPs would recommend general practice as a career. Most GPs feel motivated and involved in general practice, they feel that they can rely on their colleagues for help and support, and they believe that they have a good work-life balance. However, only about one-third (36 percent) of GPs feel that they have enough time to complete all of their daily tasks.

For the first time, the survey also investigated incidents of bullying, discrimination and sexual harassment in general practice. The majority (82 percent) of GPs had not personally experienced bullying, discrimination or sexual harassment from a health sector colleague in the past 12 months. However, 11 percent of GPs reported experiencing bullying, seven percent reported experiencing discrimination and one percent reported experiencing sexual harassment. Female GPs were slightly more likely to report incidents of bullying, discrimination or sexual harassment than male GPs. The rates experienced by registrars, overseas-trained GPs and Māori GPs are largely reflective of the rates experienced by all GPs.

1 For the purposes of the survey 'working part-time' is defined as working less than 36 hours per week and includes time spent conducting face-to-face consultations as well the time spent on paperwork, practice management, teaching, and time actually worked when on call.

The incidence of 'burn-out' and bullying in general practice are of particular concern, and these are issues that the College will need to address. Some action is already under way. The College has recently revised its self-care resource to better support GPs who experience 'burn-out', bullying and other factors that impact on their wellbeing. In addition, we are taking steps to better allow the College to report and act on bullying of registrars. We will also be looking at other ways we can better protect GPs, and ensure they remain safe and well in their practice.

HOURS SPENT WORKING IN GENERAL PRACTICE

Half of all GPs spend less than 36 hours per week working in general practice

There is wide variation in the hours worked per week by GPs. However, one-half of GPs (51 percent) say they spend 36 hours or more in the average week working in general practice, with the remaining 49 percent working part-time (Table 1).

For the purposes of the survey, 'working part-time' is defined as working less than 36 hours per week and includes time spent conducting face-to-face consultations, as well as time spent on paperwork, practice management, teaching, and time actually worked when on call, or providing after-hours care, but not the time spent on any medical work outside of general practice.

The number of hours worked in general practice per week varies significantly by gender. Two-thirds (67 percent) of male GPs report they usually spend 36 hours or more working in general practice per week, compared with 36 percent of female GPs.

Table 1: Total hours worked in general practice per week (n=1,820)

Q3 Which one of the following best represents the total hours per week you usually work in general practice?

Unweighted base =	All GPs 1,820 %	Male GPs 824 %	Female GPs 976 %
1-10 hours per week	4	4	4
11-20 hours	12	7	16
21-30 hours	18	8	26
31-35 hours	15	13	17
36-40 hours	18	20	16
41-45 hours	13	17	10
46-50 hours	8	12	5
51-55 hours	5	7	2
56-60 hours	4	6	2
61 hours or more	3	5	1
Don't know	0	0	0
Total	**100**	**100**	**100**
Mean (hours spent working in general practice per week)	35	39	31

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

TIME SPENT DOING FACE-TO-FACE CONSULTATIONS AND PAPERWORK

The majority of a GP's working week is spent in face-to-face consultations

GPs working 36-40 hours per week were estimated to spend a mean of 29 hours per week in face-to-face consultations. There was little difference between male and female GPs, although the proportion of time spent on face-to-face consultations was slightly higher among male GPs (79 percent) than female GPs (76 percent) (Table 2).

The estimated mean number of face-to-face consultations per week was also higher for male GPs (102 consultations) than female GPs (87 consultations). The estimated mean number of consultations per hour was 3.3 per hour and again this was higher for male GPs (3.4 per hour) than for female GPs (3.0 per hour).

Some of this gender difference may result from the hours worked by female GPs tending to be towards the lower end of the 36-40 hour range compared with male GPs. This was noted in the 2015 survey where respondents had the opportunity to provide actual hours worked in addition to selecting the appropriate hours range.

Table 2: Hours spent consulting and number of face-to-face consultations per week (n=1,820)

	Estimated mean hours consulting per week	Estimated mean hours consulting per week as a % of total hours worked	Mean number of face-to-face consultations per week	Estimated mean consultations per hour consulting	Number of respondents
Male respondents	30	79	102	3.4	157
Female respondents	29	76	87	3.0	139
All respondents	**29**	**76**	**95**	**3.3**	**298**

Source: RNZCGP-Workforce Survey, 2016.

One-half of GPs spend at least five hours per week on patient-related paperwork

GPs were asked about the time they spent on the following activities: patient-related paperwork; liaising with other health providers; continuing professional development; teaching medical students or registrars; and practice management (e.g. dealing with staff).

Patient-related paperwork was the most time-consuming of these tasks, with almost one-half of GPs stating that they spend six hours or more on this task (43 percent) (Table 3). GPs working 36-40 hours per week were estimated to spend a mean of 5.3 hours per week on paperwork.

The estimated proportion of the week spent on paperwork was slightly higher among those working fewer hours per week. GPs working 36-40 hours per week spent an estimated 14 percent of their time on paperwork compared with an estimated 18 percent spent by those working 21-30 hours per week.

Table 3: Total hours spent on patient-related paperwork per week, by hours worked in general practice per week (n=1,820)

Q6. How much time per week do you spend on patient-related paperwork?

Hours spent on patient related paperwork per week	Hours worked per week (Unweighted base)						
	All GPs (1,820) %	1-20 (296) %	21-30 (328) %	31-35 (269) %	36-40 (324) %	41-50 (395) %	51 or more (205) %
Up to 1 hour	6	15	4	6	4	4	0
2 hrs	14	28	15	8	11	12	7
3 hrs	14	21	17	16	13	11	8
4 hrs	13	14	17	16	15	10	4
5 hrs	10	7	12	9	15	8	7
6 hrs	12	6	16	15	12	13	8
7 hrs	5	3	6	5	6	4	5
8 hrs	8	2	5	11	10	11	12
9 hrs	3	1	2	3	1	4	6
10 hrs or more	15	2	4	10	13	24	43
No time spent on this activity	0	1	0	0	0	0	0
Don't know	0	0	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Mean (hours spent on patient related paperwork per week)	5.3	3.2	4.6	5.3	5.3	6.2	7.7

Total may not sum to 100% due to rounding.

AFTER-HOURS COMMITMENTS

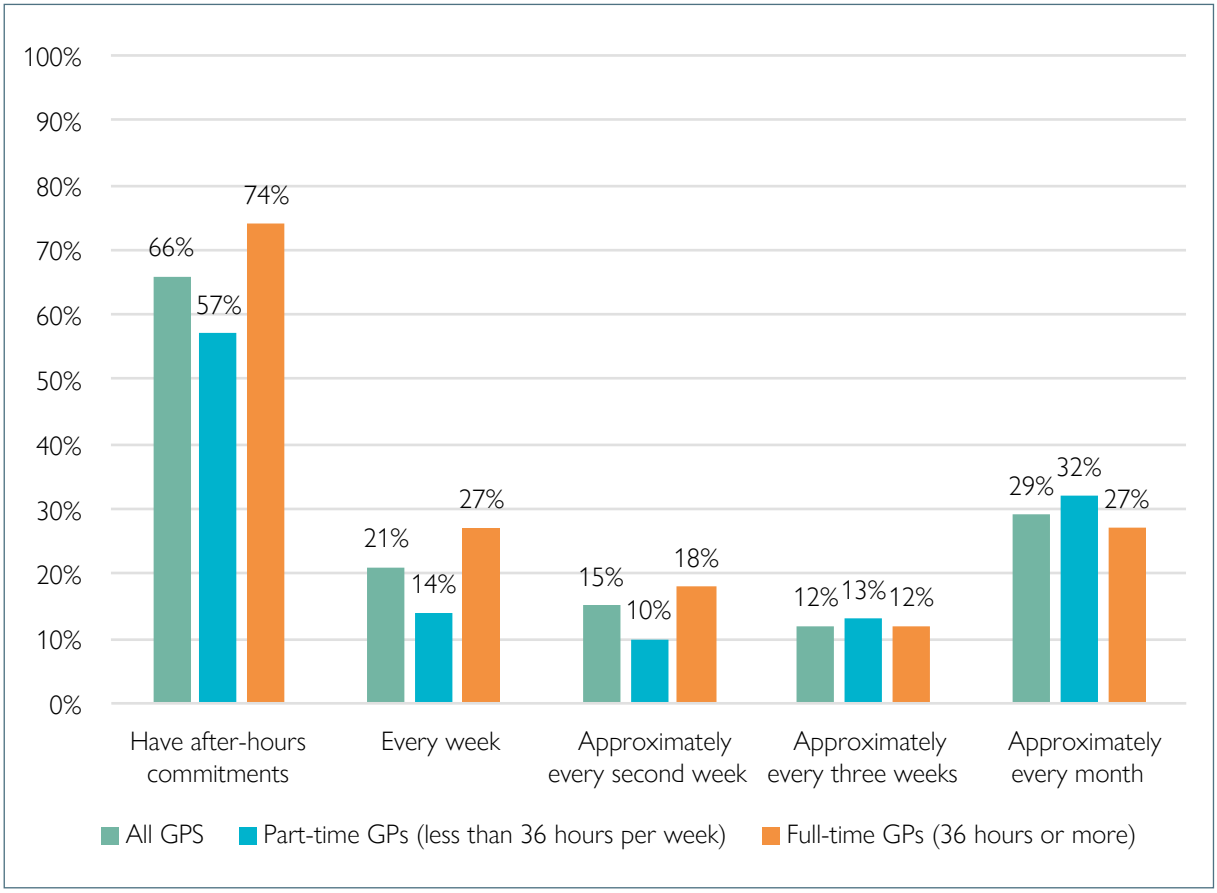
Many GPs have after-hours general practice commitments

GPs working full-time were more likely than GPs working part-time to have after-hours general practice commitments to provide acute care (74 percent and 57 percent respectively) (Figure 1).

Male and female GPs working full-time are as likely as each other to report they have after-hours general practice commitments to provide acute care (75 percent and 73 percent respectively).

Figure 1: After-hours general practice commitments, by full-time/part-time weekly status (n=1,820)

Q7. Do you have any after-hours general practice commitments to provide acute care?



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

After-hours general practice commitments also vary depending on whether the GP is working in an urban practice or a rural practice. As shown in Table 4, when GPs working full-time are compared, rural GPs are more likely to have after-hours commitments than their urban-based counterparts (83 percent and 71 percent respectively).

Table 4: After-hours general practice commitments by full-time GPs, by urban or rural based (n=923*)

Q7. Do you have any after-hours general practice commitments to provide acute care?

Unweighted base =	Full-time GPs (36 hours or more) 923* %	Urban 652 %	Rural 170 %	Not clearly urban or rural 101 %
No	26	29	17	20
Yes	74	71	83	80
Total	**100**	**100**	**100**	**100**
Unweighted base =	**686****	**464**	**141**	**81**
Every week	27	20	52	19
Approximately every second week	18	17	21	22
Approximately every three weeks	12	14	5	12
Approximately every month	27	30	14	27
Less frequently than monthly	16	18	9	20
Total	**100**	**100**	**100**	**100**

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

**Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more) and have after-hours general practice commitments.

Furthermore, when the frequency of after-hours commitments is considered, the heavier load on rural GPs becomes even more evident. Among full-time rural GPs who reported having after-hours commitments, 52 percent stated they had after-hours commitments every week, compared with 20 percent of urban GPs.

OTHER PAID OR VOLUNTARY ACTIVITIES

In addition to their general practice work, many GPs also engage in other paid or voluntary activities that relate to their expertise as a doctor

Forty-two percent of all GPs report that they spend time on other activities (outside of their general practice work) that relate to their expertise as a doctor. This includes work for organisations such as the Ministry of Health, district health boards, ACC, Medical Council of New Zealand, universities, insurance companies or the College and they also do work, which is often voluntary, organising or participating in health-related community or cultural activities, meetings or hui.

Table 5 shows that most GPs spending time on these other activities spend less than six hours per week (62 percent). However, GPs working part-time who spend time on such activities are more likely to spend more than 10 hours per week on such activities (32 percent) compared with full-time GPs (eight percent).

Table 5: Time spent on non-general practice activities per week, by full-time/part-time weekly status (n=1,820)

Q9. On average, about how many hours per week, in total, do you usually spend doing these activities?

Unweighted base =	All GPs 1,820 %	Part-time GPs (less than 36 hours per week) 893 %	Full-time GPs (36 hours or more) 924 %
No non-general practice activities	58	59	57
Spend time each week on non-general practice:	42	41	43
Total	**100**	**100**	**100**
Unweighted base =	**767***	**369**	**396**
• Up to 5 hours per week	62	51	73
• 6-10 hours	15	15	15
• 11-15 hours	5	8	2
• 16-20 hours	5	7	2
• 21-25 hours	3	5	1
• 26-30 hours	2	4	1
• 31-35 hours	2	4	1
• More than 35 hours	2	4	1
• Don't know	4	3	5
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who spend time on non-general practice activities each week.

The extent to which GPs spend time on these activities also varies by gender. Full-time male GPs are more likely than full-time female GPs to engage in such activities (46 percent and 38 percent respectively) (Table 6).

Table 6: Time spent on non-general practice activities per week by full-time GPs, by gender (n=924*)

Q9. On average, about how many hours per week, in total, do you usually spend doing these activities?

Unweighted base =	Full-time GPs (36 hours or more) 924* %	Male GPs 559 %	Female GPs 355 %
No non-general practice activities	57	54	62
Spend time each week on non-general practice:	43	46	38
Total	**100**	**100**	**100**
Unweighted base =	**396****	**257**	**136**
• Up to 5 hours per week	73	74	71
• 6-10 hours	15	16	14
• 11-15 hours	2	2	2
• 16-20 hours	2	2	3
• 21-25 hours	1	1	1
• 26-30 hours	1	1	0
• 31-35 hours	1	1	0
• More than 35 hours	1	0	1
• Don't know	5	2	8
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

**Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more) and spend time on non-general practice activities each week.

MOTIVATION AND INVOLVEMENT IN GENERAL PRACTICE

GPs feel motivated and involved in general practice, and most would recommend it as a career

This year's survey also investigated GPs' attitudes towards general practice, with the results showing more than three-quarters of GPs agreed they were motivated and involved in general practice (78 percent) (Table 7).

Eighty-one percent agreed that they could rely on their colleagues for help and support. However, much smaller proportions felt they had good work-life balance (58 percent) and that they have enough time to complete all their daily tasks (36 percent). Overall, nearly three-quarters would recommend a career in general practice (73 percent).

For the first time, the survey also investigated incidents of bullying, discrimination and sexual harassment in general practice. The majority of GPs (82 percent) had not personally experienced bullying, discrimination or sexual harassment from a health sector colleague in the past 12 months. However, 11 percent of GPs reported experiencing bullying, seven percent reported experiencing discrimination and one percent reported experiencing sexual harassment.

Registrars, GPs who qualified overseas and GPs who identify as Māori are as likely as other groups of GPs to report rates of bullying, discrimination or sexual harassment. On the other hand, GPs who work in rural general practices are more likely than those working in urban-based general practices to state they have been bullied.

Tables 7, 8 and 9 present these results by age, location and gender. There are significant differences by age, with GPs aged 40-64 years recording less positive results than those aged 25-39 years, and those aged 65 years and over on many of these questions.

For example, 74 percent of GPs aged 40-64 years felt motivated and involved in general practice and 79 percent could rely on their colleagues for help and support, which is significantly fewer than younger GPs aged 25-39 years (85 percent and 88 percent respectively).

GPs aged 40-64 years were also less likely to feel they had good work-life balance (53 percent) and enough time to complete all their daily tasks (32 percent), compared with younger GPs aged 25-39 years (70 percent and 41 percent respectively). GPs aged 40-64 years were also less likely to recommend a career in general practice (68 percent compared with 87 percent for younger GPs aged 25-39 years).

Table 7: Attitudinal profile of GP groups by age (n=1,820)

Unweighted base =	All GPs 1,820 %	25-39 412 %	40-64 1248 %	65+ 152 %
% agreeing:*				
• I feel motivated and involved in general practice	78	85	74	82
• I usually have enough time to complete all my daily tasks	36	41	32	53
• I can rely on my colleagues for help and support	81	88	79	85
• I believe I have good work-life balance at present	58	70	53	63
% experienced bullying	11	12	12	7
% experienced discrimination	7	7	7	6
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82	82	82	88
% rating their health positively**	77	72	77	79
% who would recommend a career in general practice^	73	87	68	77

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

There are also significant differences by location, with GPs working in urban locations being slightly less likely than GPs working in rural locations, for example, to state they feel motivated and involved in general practice (78 percent and 81 respectively) (Table 8).

On the other hand, GPs working in rural locations are more likely than GPs working in urban locations, for example, to state they have experienced some form of bullying, harassment or discrimination in the last 12 months (24 percent and 16 percent respectively).

Table 8: Attitudinal profile of GP groups by location (n=1,820)

Unweighted base =	All GPs 1,820 %	Urban 1,352 %	Rural 280 %	Not clearly urban or rural 184 %
% agreeing:*				
• I feel motivated and involved in general practice	78	78	81	75
• I usually have enough time to complete all my daily tasks	36	38	34	34
• I can rely on my colleagues for help and support	81	81	82	83
• I believe I have good work-life balance at present	58	58	57	54
% experienced bullying	11	10	17	11
% experienced discrimination	7	6	8	7
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82	84	76	80
% rating their health positively**	77	76	75	74
% who would recommend a career in general practice^	73	75	74	68

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

There are fewer differences by gender, although male GPs were more likely than female GPs to report having enough time to complete all their daily tasks (40 percent, compared with 33 percent for female GPs) (Table 9).

Female GPs were more likely to rate their health positively than male GPs (80 percent and 75 percent respectively), but they were more likely than male GPs to report they had experienced some form of bullying, discrimination or sexual harassment in the last 12 months (19 percent compared with 15 percent respectively).

Table 9: Attitudinal profile of GP groups by gender (n=1,820)

Unweighted base =	All GPs 1,820 %	Male 770 %	Female 641 %
% agreeing:*			
• I feel motivated and involved in general practice	78	76	79
• I usually have enough time to complete all my daily tasks	36	40	33
• I can rely on my colleagues for help and support	81	79	83
• I believe I have good work-life balance at present	58	56	60
% experienced bullying	11	10	13
% experienced discrimination	7	5	8
% experienced sexual harassment	1	0	1
% reporting none of the above	82	85	81
% rating their health positively**	77	75	80
% who would recommend a career in general practice^	73	74	73

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

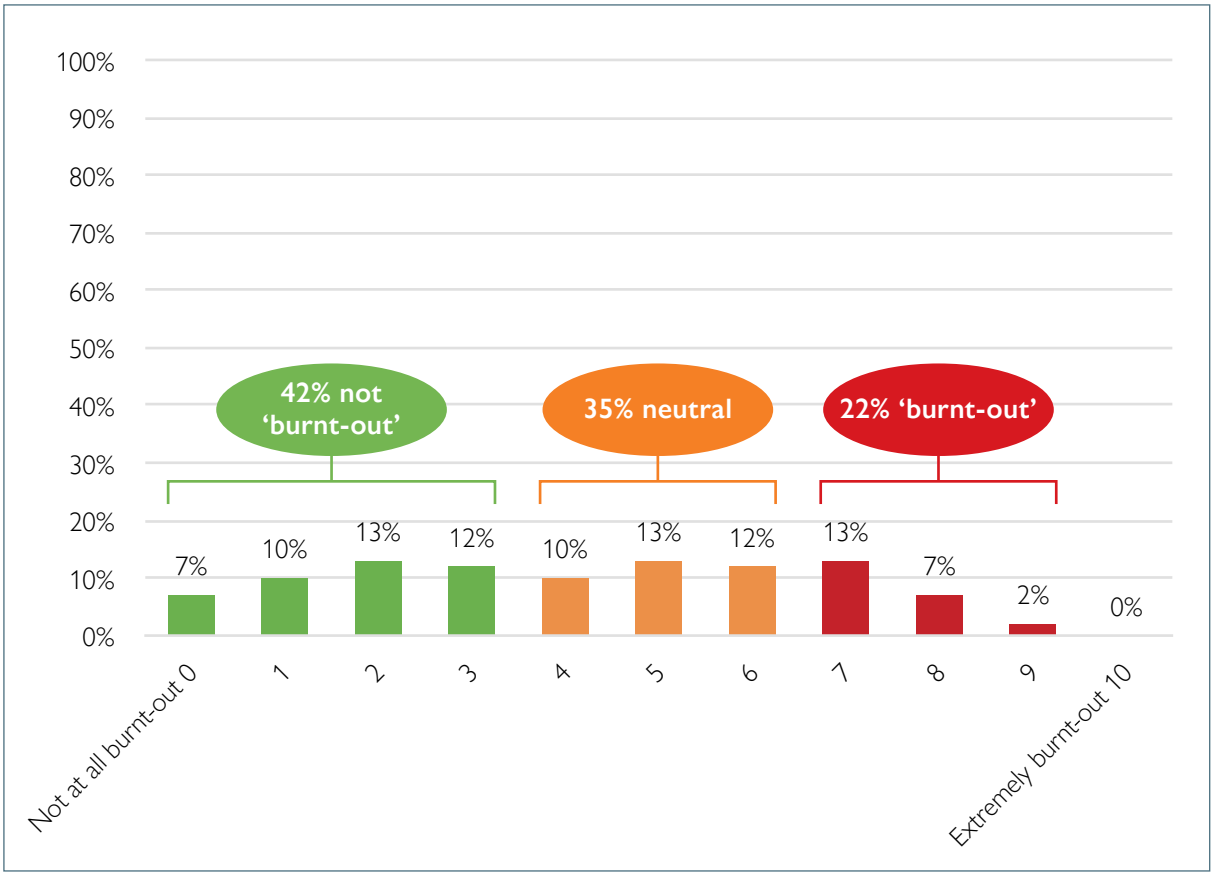
‘BURN-OUT’

One-in-every five GPs feels ‘burnt-out’

Figure 2 shows that 22 percent of GPs rate themselves 7 or above, on a 0-10 point scale measuring self-assessed ‘burn-out’.

Figure 2: Extent to which GPs feel ‘burnt-out’ (n=1,820)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = ‘Not at all burnt-out’ and 10 = ‘Extremely burnt-out’?



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Who is 'burnt-out'?

Table 10 and Figure 3 profile GPs in the three groups reflecting the extent to which they state they are or are not 'burnt-out'. Table 10 shows that, in terms of their work practice, the group of GPs who feel 'burnt-out' are significantly different from the group who state they are not 'burnt-out':

- They are **more likely** to work full-time in general practice (66 percent of those 'burnt-out' work full-time in general practice compared with 42 percent of those who are not 'burnt-out').
- They are **more likely** to have after-hours general practice commitments (71 percent, compared with 62 percent of those who are not 'burnt-out').

Table 10: Working profile of GP groups based on the extent to which GPs report themselves as being 'burnt-out' (n=1,820)

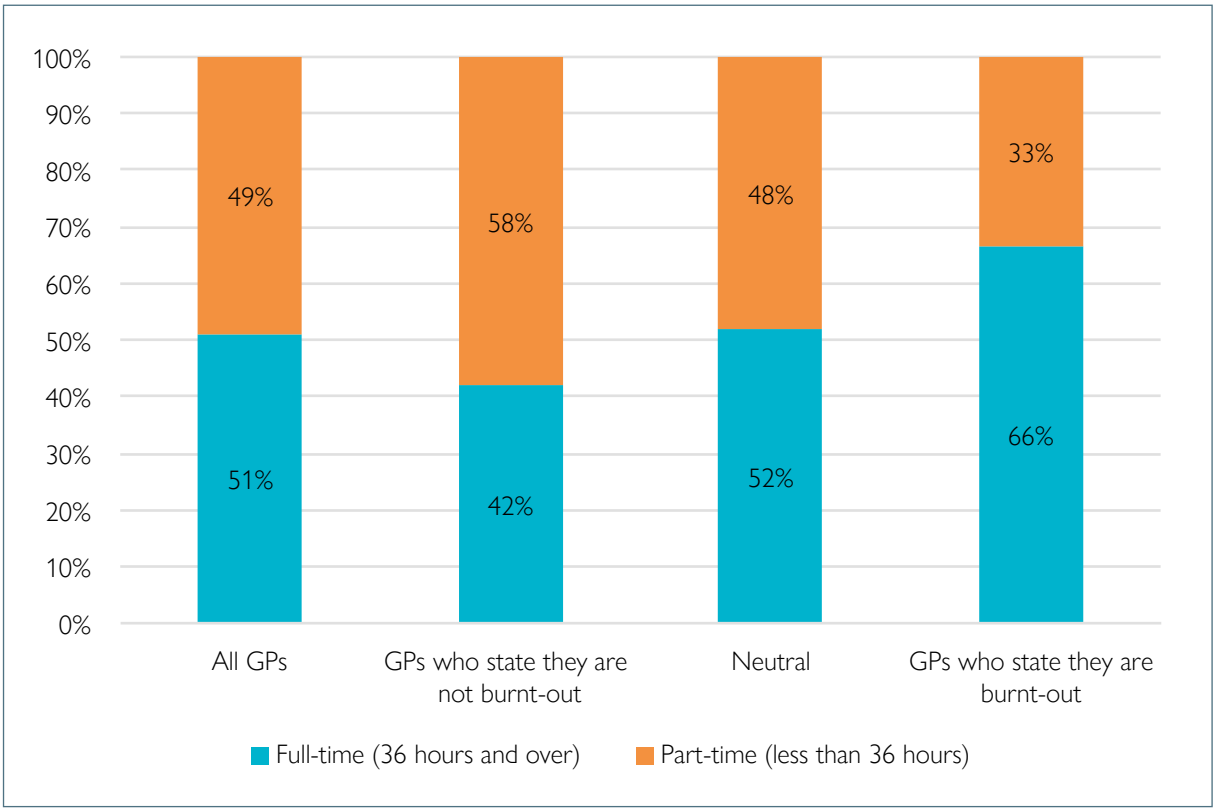
Unweighted base =	All GPs 1,820 %	GPs who state they are not 'burnt-out' 770 %	Neutral 641 %	GPs who state they are 'burnt-out' 409 %
% who spend 26 hours or more per week consulting with patients*	35	29	35	45
% who have 81 or more face-to-face consultations per week*	43	37	40	55
% who spend six or more hours per week on patient-related paperwork*	53	46	55	61
% who have weekly after-hours general practice commitments	66	62	66	71

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

* Based on the mean for all GPs.

Figure 3: Levels of 'burn-out' by full-time/part-time weekly status (n=1,820)



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

As shown in Tables 11 to 16, GPs who report feeling 'burnt-out' are also **more likely** than GPs who state they are not 'burnt-out' to be:

- Working in general practice on a full-time basis (29 percent of GPs working 36 hours or more in general practice per week, compared with 15 percent of GPs working up to and including 35 hours per week).
- Aged 40-54 years or 55-64 years (25 percent and 26 percent respectively, compared with 16 percent of GPs aged 25-39 years and 15 percent of those aged 65 years and older).
- A practice owner or partner (29 percent, compared with 19 percent of long-term employees and 15 percent of short-term employees).
- Planning to retire within the next five years (30 percent compared with 20 percent of those GPs who are planning to retire in six years' time or more).
- Working in a practice that currently has a vacancy for a full-time-equivalent doctor (27 percent compared with 21 percent of those GPs who had a vacancy in the last 12 months, and 20 percent of those who had not had a vacancy in the last 12 months).

GPs who work in rural general practices, GPs who are registrars, GPs who qualified overseas and GPs who identify as Māori are as likely as other groups to state they are 'burnt-out' or not 'burnt-out'.

Table 11: Levels of 'burn-out' by full-time GPs, by gender (n=924*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Full-time GPs (36 hours or more) 924* %	Male GPs 559 %	Female GPs 355 %
Not 'burnt-out' (0-3)	35	36	33
Neutral (4-6)	36	35	37
'Burnt-out' (7-10)	29	29	30
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

Table 12: Levels of 'burn-out' by part-time GPs, by gender (n=893*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Part-time GPs (35 hours or less) 893* %	Male GPs 263 %	Female GPs 620 %
Not 'burnt-out' (0-3)	50	51	50
Neutral (4-6)	35	33	35
'Burnt-out' (7-10)	15	16	15
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked part-time (i.e. 35 hours or less).

Table 13: Levels of 'burn-out' by age (n=1,820)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,820 %	25-39 years 412 %	40-54 years 678 %	55-64 years 570 %	65+ years 152 %
Not 'burnt-out' (0-3)	42	44	39	39	63
Neutral (4-6)	35	39	36	35	22
'Burnt-out' (7-10)	22	16	25	26	15
Total	**100**	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Table 14: Levels of 'burn-out' by whether a practice owner or not (n=1,816*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,816 %	Practice owner/ partner 697 %	Long-term employee/ contractor 837 %	Short-term employee/ contractor (e.g. locum or GP registrar) 258 %
Not 'burnt-out' (0-3)	42	36	44	53
Neutral (4-6)	35	35	36	33
'Burnt-out' (7-10)	22	29	19	15
Total	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Table 15: Levels of 'burn-out' by those planning to retire within five years and those planning to retire later (n=1,816*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Total 1,816* %	1 to 5 years from now 413 %	6 years or longer 1,403 %
Not 'burnt-out' (0-3)	42	43	42
Neutral (4-6)	35	27	38
'Burnt-out' (7-10)	22	30	20
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those who provided a response.

Table 16: Levels of 'burn-out' by current GP vacancies (n=1,804*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,804* %	Current GP vacancy 517 %	GP vacancy within the past 12 months 680 %	No GP vacancies within the past 12 months 607 %
Not 'burnt-out' (0-3)	42	38	44	43
Neutral (4-6)	35	34	35	36
'Burnt-out' (7-10)	22	27	21	20
Total	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those who provided a response.

FACTORS ASSOCIATED WITH 'BURN-OUT'

What are the factors associated with being 'burnt-out'?

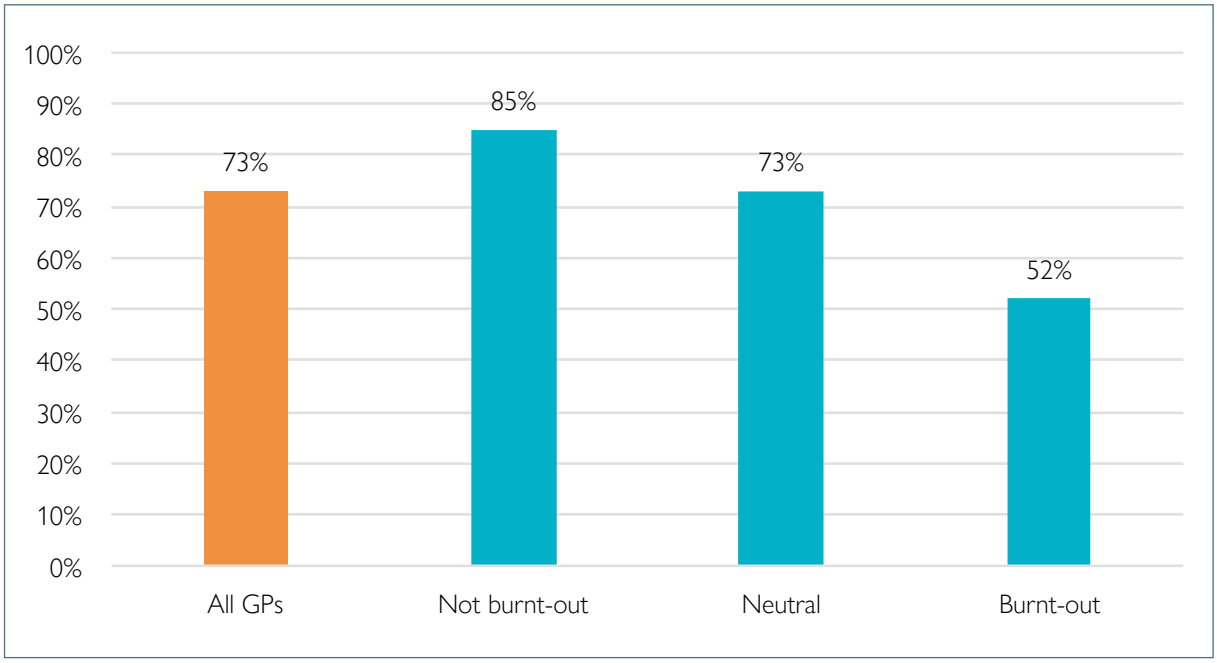
'Burn-out' is also associated with a GP's reported health and general outlook about a career in general practice.

As shown in Table 17, GPs who report feeling 'burnt-out' are generally less likely to respond positively to questions about their motivation, or their health, and to recommend general practice as a career:

- As shown in Figure 4, they are **less likely** to recommend a career in general practice (52 percent, compared with 85 percent of those GPs who state they are not 'burnt-out').

Figure 4: Percentage of GPs likely to recommend a career in general practice by levels of 'burn-out' (n=1,820)

Q10. How likely is it that you would recommend a career in general practice?



Source: RNZCGP-Workforce Survey, 2016.

Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

- A **lower percentage** of those feeling 'burnt-out' state they feel motivated and involved in general practice (57 percent, compared with 88 percent of those GPs who state they are not 'burnt-out').
- A **lower percentage** also state they usually have time to complete all their daily tasks (13 percent, compared with 55 percent of those GPs who state they are not 'burnt-out').
- A **lower percentage** also state they have good work-life balance (23 percent, compared with 81 percent of those GPs who state they are not 'burnt-out').

- A **higher proportion** state they have been bullied (18 percent) and experienced discrimination (11 percent), compared with seven percent and four percent respectively of those GPs who state they are not 'burnt-out'.
- A **lower proportion** rate their health as good or excellent (54 percent, compared with 89 percent of those GPs who state they are not 'burnt-out').

Table 17: Attitudinal profile of GP groups based on the extent to which GPs report themselves 'burnt-out' (n=1,820)

Unweighted base =	All GPs 1,820 %	Not 'burnt-out' 770 %	Neutral 641 %	'Burnt-out' 409 %
% agreeing:*				
• I feel motivated and involved in general practice	78	88	78	57
• I usually have enough time to complete all my daily tasks	36	55	28	13
• I can rely on my colleagues for help and support	81	87	81	72
• I believe I have good work-life balance at present	58	81	53	23
% experienced bullying	11	7	12	18
% experienced discrimination	7	4	6	11
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82			
% rating their health positively**	77	89	75	54
% who would recommend a career in general practice^	73	85	73	52

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

METHODOLOGY

The 2016 Workforce Survey was conducted in May and June 2016. Research New Zealand, an independent research company, was commissioned to design and conduct the survey, and to analyse and report the results. In this regard, Research New Zealand worked closely with College staff and an advisory group comprising a GP, an Otago University academic and a Health Workforce New Zealand staff member.

In total, 4,686 fellows, members and associates of the College and the Division of Rural Hospital Medicine, received an email invitation with a link to the online survey. A reminder email was sent to those who had not responded one week later. To boost the final participation rate, two more follow-up emails were sent in the subsequent weeks.

The College database, which includes the vast majority of doctors working in New Zealand general practice, was used to identify and contact survey recipients. It should be noted that in New Zealand doctors are legally able to work in general practice without the additional training required for vocational (specialist) registration, and these non-vocationally registered doctors are not usually included in the College database.

A total of 2,087 valid responses were received by the survey close-off date, giving a response rate of 44.5 percent. This included eight incomplete responses which were included in the analysis, given that the answers to only a small number of the survey questions were missing.

Approximately 100 respondents stated they had only worked in rural hospital medicine and these respondents were excluded from the analysis. Additionally, some respondents were doctors that were not part of the current workforce (e.g. they were retired or were working overseas). These respondents were also excluded from the analysis. As a result, unless otherwise specified, the data and analysis in this report is based on the responses to the survey questions for 1,820 respondents who stated they had worked in general practice in New Zealand in the three months prior to the survey.

A comparison of the age and gender profile of survey respondents to the age and gender profile of those on the College database was also undertaken. As this showed a close match between the two profiles, the survey data has not been weighted to correct for any variations.

Therefore, all data in this report is presented on an unweighted basis. Not all questions were compulsory and the survey was structured so that respondents were not asked questions that were not relevant to them. Therefore, the totals in the tables differ according to the number of doctors who responded to the relevant question.

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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
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Submission information
This submission is on behalf of: ~~Individual~~ ☐ **Group** ☐ **Name: Professor Michael Baker** **Position/title: Director of Continuing Professional Development** **Organisation: New Zealand College of Public Health Medicine** **Do you agree to your submission, or parts of your submission being published**: **Yes** ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: **Not required**
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The NZCPHM supports the principle that doctors use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. However, obtaining meaningful performance and outcome data is very difficult. We are not aware of any areas of medical practice in New Zealand where such data are routinely available in a form that would enable robust measurement of performance of individual clinicians. Patient outcomes are affected by a multitude of factors. It would probably be more effective, and a better use of resources, to use such data to identify potential improvements in health care systems rather than the performance of individual practitioners. This is an area where organisations such as the Ministry of Health and Health Quality and Safety Commission should be in a position to provide leadership. From a technical perspective, such work

falls within the scope of practice of public health physicians (using epidemiological methods).

We consider it important to select the mix of methods that is fit for purpose. For example, in a non-clinical area like public health medicine it is not appropriate to use performance and outcome data that relates to individual patients. Multisource feedback is however quite appropriate.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

The NZCPHM supports the use of an individualised PDP for each doctor as a central part of recertification. We also support the requirement that doctors will be expected to review their own PDP each year, with input from an external reviewer. This is already a requirement in our recertification programme (TOPS).

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The NZCPHM considers that it will be difficult for a medical college to define the knowledge requirements for their vocational scope(s) of practice and to incorporate these requirements into their recertification programmes. Knowledge requirements for effective practice are extremely large and complex and constantly evolving. These requirements are also diverse across specialist and sub-specialist areas.

We consider that it might be more effective to express knowledge standards in terms of competencies. This is the approach that our College has taken (with a highly structured listing of 116 *Public Health Medicine Competencies* covering training and specialist practice).

We support the inclusion of cultural competencies as an explicit requirement within all medical recertification programmes.

One area where there may be benefit in specifying knowledge requirements could be around professional practice requirements that apply to all medical practitioners. This could include knowledge contained in

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

key documents produced by the MCNZ and Health and Disability Commissioner. There would be obvious efficiency benefits in the MCNZ specifying such knowledge requirements for all practitioners along with setting up mechanisms for doctors to assess and update their knowledge in such areas.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The NZCPHM wishes to provide qualified support for this proposal. We note the statement in the consultation paper that "…each medical college would need to develop an RPR model appropriate for their vocational scope(s)." We think that this flexibility of approach is critical to the success of the RPR. Otherwise this tool will be unhelpful and poorly implemented.

In the case of public health medicine, the content and style of practice is hugely variable across different settings. Consequently, the NZCPHM argues that the PRP function is best met by the annual PDP process combined with operation of peer review groups. We propose strengthening this process by increasing emphasis on 'structured conversation with a designated senior colleague' as part of setting and reviewing the PDP. We are also working to introduce a 3-yearly MSF to supplement these review processes and provide additional input into the PDP process.

As noted under Question 9, we have concerns about the potential negative impact of simply adding more recertification requirements without removing others. We would favour careful prioritisation of such tools based on evidence of effectiveness and efficiency. In this instance, we think that a focus on annual PDPs and 3-yearly MSF would probably be relatively effective and efficient recertification requirements for all medical practitioners. RPRs could potentially be prioritised for specialist scopes of practice where direct observation of procedural skills is an important quality assurance requirement.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The NZCPHM acknowledges that the individual professional development needs of specialists vary considerably. However, the capacity of Medical Colleges to provide individualised support for specialists is inherently quite limited. Instead, we are promoting greater self-management of this support function through participation in peer review groups, which is a requirement of our recertification programme.

We are also considering mechanisms to strengthen the support role of our recertification programme (TOPS) particularly for specific demographic groups of TOPS participants who may have additional needs

for support (eg newly qualified specialists, newly migrated specialists, specialists reaching retirement age, those not participating or not meeting requirements, or where the College is aware of performance/competency concerns). However, we consider that such support may often be best provided by well-functioning peer review groups.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Career management planning is likely to be useful throughout our working lives. Much of this planning is probably generic across all medical specialties. At the very least, such advice could be provided as an on-line service. The MCNZ might be well-placed to provide such a service (either directly or through a contracted provider).

The NZCPHM considers it important to avoid ageism and other forms of discrimination that could (perhaps unintentionally) become incorporated into recertification programmes. For example, recertification requirements should be based on performance rather than chronological age. We encourage the MCNZ to identify positive models for how older practitioners can continue to contribute effectively and safely to the broad field of medicine.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The NZCPHM supports effective monitoring and evaluation of recertification programmes and the use of such information to support continuous quality improvement. In our own case, we conduct a systematic review of our recertification programme (TOPS) every 3 years. This process includes review of quantitative data about participation in the programme and collection of survey data from participants and key informants. Findings are synthesised into a set of proposed improvements which are then consulted on and implemented following suitable review through the College's governance mechanisms.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

We support taking an approach that is goal-focused and principle-based.

Although this current consultation is not focussed on reviewing these principles, we would suggest two additions to the current list:

- Efficient, with the minimum necessary complexity and compliance costs
- Systems focused, promoting behaviours that improve public health and reduce health inequalities

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Challenges and approaches

1. **Taking a population health perspective** – Recertification programmes are just a means to an end. The main test is whether they drive a culture shift and real behaviour changes resulting in improved patient outcomes, better public health, and reduced health inequities. There are multiple factors contributing to whether they will succeed. One of these factors is 'face validity' - they must be seen as sensible and useful. This positive perception will be enhanced if the evidence-base for changes is clearly presented. Similarly, the proposal contains multiple references to the collection and use of robust data (such as 'good quality performance and outcome data' and 'collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme'). In general, such data are difficult to obtain. These kinds of questions are very much within the scope of public health medicine practice. We consider there may be advantages to the MCNZ in establishing a position within its office for a public health medicine specialist and/or registrar to provide ongoing support for this vital quality assurance work.

2. **Achieving effective uptake –** Slow, partial, and perfunctory uptake of these recertification requirements will seriously limit their effectiveness. To minimise this problem it will be important to develop their 'face validity', as noted above. It will also be important to keep these recertification requirements as simple and easy to understand and comply with as possible. Not changing them too often is also helpful so that they can become embedded in medical and public health thinking. It will almost certainly be more effective to have a small number of well accepted, easily understood, and durable requirements, rather than a large number of measures of uncertain value. In this regard, it is not clear from this consultation whether some current recertification requirements will be dropped. The consultation paper mentions the current recertification requirements, including peer review and continuing medical education (CME), and describes the need for a new approach. However, it doesn't appear to propose dropping any of these current recertification requirements. Is that interpretation correct?

3. **Adapting to different areas of specialist practice** – The kinds of recertification programmes needed for specialists performing large numbers of specific surgical procedures for example, are very different to those appropriate for areas such as public health medicine. We think it is important to recognise these differences and provide flexibility where this is needed.

4. **MCNZ support for effective recertification systems** – Where recertification requires development of systems that are likely to be very similar for all medical colleges, there is a strong case for MCNZ leadership in developing the national infrastructure for such systems, or commissioning such work. There are at least 15 medical colleges and 36 specialties in the NZ health system. Rather than each of them developing separate systems, there are obvious efficiency, quality, and timeliness benefits in them using the same system or variations of the same systems for carrying out similar processes. An obvious example is MSF where BPAC has emerged as an effective and efficient provider of such services for multiple end-users. We think the MCNZ should be proactive in identifying other areas where a common service provider can assist, and supporting this process (ideally through coordination and purchasing of shared services).

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Three years is probably too soon to get all of these elements in place for all specialists working in all vocational groups.

A staged approach may be more attainable. For example, it should be quite feasible to introduce PDPs quite quickly (for those specialists groups who don't have this requirement already).

Having MSF operating for all colleges may take longer.

The MCNZ needs to be aware that Colleges' development and committee processes take considerable time, as does the implementation of changes to online recertification systems through IT providers.

We recommend a 5 year implementation period.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Submission information
This submission is on behalf of: Individual □ Group ☑ **Name: Dr Lance Lawler (Chair NZ Branch Committee) and Dr Chris Atkinson (Chair NZ Radiation Oncology Executive Committee** **Position/title:** **Organisation:** Royal Australian and New Zealand College of Radiologists **Do you agree to your submission, or parts of your submission being published**: Yes ☑ No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes □ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
RANZCR agrees with the Council's view that a professional development plan (PDP) will benefit a doctor to target his/her Continuing Medical Education (CME) activities to rectify areas for improvement which may be identified and performance and outcome data could be used. Providing doctors with support in respect of their individual professional development plans is a role that the College could participate as the College could assist with providing possible benchmarks for practice. But we believe that it is not practical to involve the College in this as a single resource. Firstly, a degree of familiarity with a doctor's practice is required to assist with this, and therefore it is not practical for officers of the College to be involved. It is best done locally, with assistance sought from

a senior colleague, such as Clinical Director. Similar activity already exists as part of annual performance appraisals. We, therefore, believe that employers would be better placed to support individual doctor's professional development plans. A doctor's performance and outcome data could be the annual audit. However, this may or may not be relevant to the clinicians PDP.

Secondly, we also have concerns about the resource implications for Colleges being involved in this activity.

We, therefore, believe that the College could only realistically assist with PDP development by supplying generic guidance or suggestions, or by offering activities such as contouring workshops at conferences or sub-speciality interest groups within the framework of the College helping to identify specific training opportunities, if approached.

Proposal:

Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

RANZCR agrees that Continuous Professional Development (CPD) may be better when linked to performance assessments and an individual's learning needs and that an individualised PDP is a worthwhile part of recertification. However, duplication of effort should be avoided. As noted above, annual performance appraisals, which are similar, are currently common in District Hospital Boards (DHBs).

We believe that clinicians can and should set goals and that an annual review is reasonable. However, we suggest that a longer period of time should be offered for meeting PDP targets, as appropriate CME opportunities for identified weaknesses may not be accessible every year.

Proposal:

Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence1, cultural competence, and the Code of Health and Disability Services Consumer's Rights.

Question 3:

What is your view of medical colleges defining knowledge requirements?

We believe that if this is to be required, the colleges are best placed to do this for their speciality and already define the level of knowledge expected of a practitioner through the training curriculum. Issues

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

such as 'cultural competence' and 'consumer's rights' are included. However, a review by the appropriate committees may be required periodically to ensure that the Council's priorities with regard to allied aspects of the curriculum, such as these, are suitably addressed.

However, if the Medical Council of New Zealand (MCNZ) view of defining knowledge requirements is something other than the content currently existing in the training curriculum, then the MCNZ are requested to provide some examples., there would considerable resource implications for the College if defining knowledge requirements involves more than the current content of the training curriculum as this would need to be done by clinicians, who are already busy.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The goal of RPR is to help individual doctors identify areas where aspects of their performance could be improved, benefiting not only their own professional development but also the quality of care that their patients receive.

However, the biggest obstacle to the widespread adoption of RPR is the MCNZ requirement that this must include some component of external assessment that is by peers external to the doctor's usual practice setting. We believe that to do these assessments well would require very thorough work from another Fellow from the speciality. In a health system that is facing pressure due to workforce shortages, the logistics of setting up such a system could be daunting. Unless employers are willing enablers of such activities, it is difficult to see it being carried out among the Radiation Oncology workforce in New Zealand as a matter of routine.

In New Zealand the vast majority of radiation oncologists work in public practice and the DHBs would have to agree to the loss of clinical time and costs. If this is not supported by the employers, is the proposed alternative that the College i.e. the membership cover the costs? As New Zealand has around 50 Radiation Oncologists and approximately one third are considered senior, then a routine implementation of RPR would result in each senior clinician being required to visit one colleague a year. However, if only a few senior clinicians are trained to conduct these assessments, then it could be 5 or more days of lost productivity per year for the assessors and 34 days of lost productivity for DHBs. Private practitioners could also not justify the loss of income to support it without recompense.

We believe that it may be appropriate to organise such assessments, if the College is aware of concerns regarding a Fellow's practice, as per the relevant remediation guidelines.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Our response to Question 1 has mentioned that the College recommends that employers are best placed to support doctors in developing individual professional development plans due to their familiarity with the doctor's practice, their current activity with this through performance appraisals and the resource challenges that the College would face in trying to provide this level of support. Similarly, we believe that employers are best placed to provide additional support for doctors when required, as most clinicians work in an environment where they are collegially supported. The College may be able to provide support to clinicians who are isolated or on request. The College could also provide support and advice through guidelines and policies or by providing relevant programs and activities. Currently the College has an ongoing program of developing and improving support for members in respect of CPD and other areas.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

We believe that career management planning is a good idea. However, this should be dealt with sensitively through approaches such as raising awareness of career management planning, rather than approaches that could be perceived as paternalistic. This matter should be worked out locally. We believe that trying to define certain activities based on age may not be appropriate, as it introduces an unnecessary prejudice into the system and intellectual decline is not always directly related to age. We believe that the programme itself should be used to detect issues that may require learning goals or experiences across the board and we should trust these processes to detect and deal with issues, whatever the age of the practitioner. We do, however, agree that the College should respond and undertake appropriate action, in accordance with legislative requirements, whenever concerns are expressed about anyone's practice.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

An evaluation of the recertification program to meet the requirements of the MCNZ would be useful. The College currently reviews and analyses the current CPD program to ensure relevance and continuous improvement. Examples of the types of data and analysis required would be helpful to understand the breadth and depth of what is being suggested as College does not have the capacity for undertaking major analysis.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

The opening sentence on the Background section of this paper begins with stating that "doctors working in New Zealand are respected for their high standard of care and are one of the most trusted groups in New Zealand. RANZCR supports ongoing improvement but has concerns particularly in respect of the current high burn out rate and the increasing demands made on doctors.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The proposed recertification model includes an annual audit of medical practice. This is arguably the best recognised practice quality improvement activity. However, due to current pressures on practitioners, not many are able to perform useful audits. By this we mean studies such as patient outcomes directly related to treatments/interventions provided.

We believe that many doctors in our specialist area are already overburdened and there are high levels of burnout. We believe that a major challenge to implementing this system is resourcing. How would the additional work from doctors in conducting the necessary activities of this new recertification system be resourced both in terms of availability and financially? Would the DHBs be required to cover the costs of increasing their number of Full Time Equivalent doctors? Would Colleges be given additional funding to do the work required?

We suggest that the MCNZ consider solutions to these issues, such as directing employers to provide time and other resources to enable audits or providing additional funding to Colleges.

We are concerned that failing to addresses these issues may actually lead to decreased patient care, as doctors will have to make short cuts to fulfil onerous recertification requirements and colleges may need to divert funds away from training and teaching in order to fulfil these requirements.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

The RANZCR CPD program works on a 3 yearly cycle. The current cycle runs till the end of 2018. The College does not have the resources to incorporate any major additional requirements for 2019-2021. Therefore, we should request time till at least 2022 with intermediate milestones being set along the way.

AUSTRALASIAN FACULTY OF MUSCULOSKELETAL MEDICINE

PO Box 4274
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10th March 2017

Ms Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143

Email: recertificationconsultation@mcnz.org.nz

Re: MCNZ Discussion Document: "Consultation on strengthening recertification for vocationally registered doctors"

Dear Ms Davis,

The Australasian Faculty of Musculoskeletal Medicine (AFMM) and New Zealand Association of Musculoskeletal Medicine (NZAMM) appreciate the opportunity to give feedback on the MCNZ discussion document, "Consultation on strengthening recertification for vocationally registered doctors" dated 24th January 2017. The NZAMM is the gazetted VEAB responsible for the musculoskeletal medicine vocational scope in New Zealand and contracts the AFMM to provide training and recertification processes, through a Memorandum of Understanding.

We are also grateful for the formative approach that the Council takes toward recertification and emphasis on continuous quality improvement, … both for individual doctors, and for vocational scopes. Our own faculty is committed to this approach as demonstrated by forming a partnership with BPAC^{NZ} one year ago to host our recertification programme on-line and shift the emphasis from an annual stocktake by our members to a commitment to all year round continuing professional development (CPD) as an integral part of our professional working lives. In addition, the partnership has allowed us to make some gradual changes to our programme in places, and strengthen it in other areas. The AFMM CPD programme has always been based on the guidelines provided by the MCNZ and the Faculty has endeavoured to exceed the minimal recommended expectations.

In response to your guiding questions for submissions to the proposals (reproduced in italics) –

Proposal: Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

1. It is a truism that we don't know what we don't know and identifying learning needs is a challenge of recertification programmes and the individual reaccrediting doctor. Our faculty maintains a syllabus and a curriculum which we base fellowship examinations on. At this stage, we do not formally conduct ongoing testing of our existing Fellows who have previously gained fellowship by examination. We provide peer review through national weekend retreats which have a very high rate of attendance, and through peer review meetings, as well as mandatory formal regular practice reviews (RPR) which include multisource feedback. As part of recertification requirements is an annual audit by each practitioner but this has historically been the most challenging part of reaccreditation for our members. Unless all the members of the faculty conducted an identical audit across the board, it would be difficult to obtain meaningful comparisons. For example, our members do minimal prescribing, but are prescribers of high technology imaging. In addition, practices are heterogeneous with some practitioners being in private practice, some in public hospitals, and there is a wide range of services offered.

Proposal: Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

2. As part of the transition to the BPAC^{NZ} hosted service, we have introduced individualised professional development plans as part of recertification. We expect that participation will start slowly as our members adopt the changes to the programme but are committed to universal adoption over time.

Proposal: Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence, cultural competence, and the Code of Health and Disability Services Consumer's Rights.

3. As mentioned above, the Faculty maintains a syllabus and a curriculum to establish minimal standards for the musculoskeletal scope. In addition, we support the Council's statements (upon which we base many of our own policies and statements), Good Medical Practice, domains of competence, cultural competence, and the Code of Health and Disability Services Consumer's Rights. The faculty is committed to excellent practice in the delivery of musculoskeletal services to patients, as well as supporting statutory requirements which reflect the rights of patients.

Proposal: Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

4. Practice visits have been mandatory as part of recertification in the musculoskeletal scope for some years. We have now adopted the BPAC^{NZ} model completely for regular practice reviews which incorporate patient and multisource feedback. All participating doctors are expected to host a RPR at least once every three years. Most host and visiting doctors find this to be a very worthwhile process and comment that it is the most tangible and useful component of recertification.

Proposal: Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

5. The AFMM is a small faculty. The members know each other intimately. The faculty is able to respond to requests for individual support as required.

6. The MCNZ has documented the variable decline in cognitive ability in the ageing doctor. The AFMM would consider a mandatory cognitive test at certain ages if this was thought to be a useful process for practitioners and for the safety of their patients.

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

7. As the AFMM contracts BPAC^{NZ} to provide logistical support, and all reporting is computer-based, analysis of recertification is a continuing process and snapshots can be taken at any time of the year to assess compliance and provide feedback to participating individuals on their progress.

General Questions:

8. The AFMM is encouraged by the commitment of the MCNZ to evolving recertification based on evidence. Traditionally, our members have found the less evidence-based learning such as CME easier to achieve than evidence-based processes such as audits. We have a very high rate of compliance with peer review.

9. The AFMM has a commitment to cultural competence and does provide 2-yearly training sessions. We look forward to exploring treatment outcomes and measures for equality.

10. Being a smaller faculty has allowed the AFMM recertification programme to be nimble and respond quickly to recommended changes. The programme has always been based on MCNZ recommendations and exceeded the minimal requirements. The new partnership with BPAC^{NZ} has ensured that we can remain close to the cutting edge for recertification. We have adopted all of the BPAC^{NZ} processes apart from the essentials test. We see no issue with the three-year time frame proposed by the MCNZ for adoption of the proposed changes.

Thank you again for the opportunity to provide feedback on the MCNZ proposed changes to recertification.

Yours sincerely,

Dr Grant Thompson
On behalf of the AFMM CPD Committee

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RCPA
The Royal College of Pathologists of Australasia

10 March 2017

Karen Davis
Senior Project Officer
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Email: recertificationconsultation@mcnz.org.nz

Dear Ms Davis

RE: MCNZ Consultation on strengthening recertification for vocationally registered doctors

The Royal College of Pathologists of Australasia (the College) is the leading training and assessment organisation concerned with the quality and professional practice of pathology in New Zealand. As such, the College has very serious concerns over many of the proposals outlined on the Consultation Paper on Strengthening Recertification for Vocationally Registered Doctors.

There are two overarching reasons for these concerns.

Firstly there is very little or no evidence provided to support the proposed approach. The Medical Council of New Zealand (MCNZ) states that their "main purpose is to promote and protect public health and safety in New Zealand". There is no evidence presented to suggest that the changes proposed to strengthen recertification for vocationally registered doctors will achieve this outcome. Rather the changes will add to the administrative burden vocationally registered doctors practice with and reduce their time for clinical contact with their patients.

Secondly, this proposal blurs the role and lines of responsibility between the individual practitioners, the Colleges and the employers. It demands a change to the nature of the relationship between the College and Fellows imposing a reporting role that is more properly the MCNZ role. It also entails a degree of cost shifting from the MCNZ to the College and the employers and the resources involved for Colleges, employers and Fellows would be impossible to provide.

Further, the approach is very prescriptive and a "one size fits all" process. The approach taken by the Medical Board of Australia (MBA) appears to be much more practical, flexible and less resource intensive: that is; having an enhanced CPD requirement (peer review and clinical audit) and a second mechanism for identifying and remediating high risk doctors (divided into three levels). The College urges the MCNZ to consider this much better approach to the issue of recertification.

Specific comments in relation to "Proposed requirements for Medical Colleges" (p 5-6) follow:

4. Council accredited recertification programmes for vocationally registered doctors will need to meet new accreditation standards based on the following:

a) Defining Knowledge Requirements

The College training curriculum describes the key elements of what is required for contemporary practice in each discipline of pathology. These already include such issues as cultural competence. If there are additional standards the MCNZ require, the College could add these to the curriculum. Fellows could be advised of the need to align their recertification requirements with the Training Curriculum for their particular scope of practice. This is something Fellows would need to manage for themselves.

b) Identifying Professional Development Needs

The College does not have the resources beyond what is stated in a) above to use performance and outcome data to identify individual professional development needs and in no way should be required to do so.

The College has, as of 2017, made it compulsory for all Fellows to participate in Internal Quality Assurance peer review activities relevant to their discipline and scope of practice. The College's IQA Frameworks include a range of tools Fellows can choose from (including audit, internal peer review and, multi-source feedback), with 10 hours per year mandated above normal CPD requirements. Because of the different ways in which Fellows practice, the tools are not prescriptive. Further the College cannot direct what the performance development needs are for each Fellow, as this is beyond the College's capability. Further, mandatory participation in individual external quality assurance (EQA) programs has been introduced (when available in a Fellow's scope of practice).

To expect outcome data from audit and multisource feedback and external peer review is prescriptive, resource intensive and not evidenced based as far as we are aware.

5. Regular Practice Review (RPR)

Requiring each medical college to provide RPR as an option for their Fellows is not supported by the College. As previously addressed with the MCNZ, pathologists undergo intensive accreditation site visits as part of the IANZ Laboratory Accreditation process. This is a peer review process and is measured against internationally recognised ISO standards. To require further unstructured, non-standardised visits by the College is redundant. In addition, training sites are inspected for compliance with requirements for trainees (which involves many of the staff pathologists and their practice environments).

The College has reviewed the Medical Council data on RPR visits for non-vocationally registered doctors. It does not provide any evidence that the visits actually improve practice or protect the public, indeed the College is unaware of any objective evidence available that the proposed visits will do this.

Further the College is concerned that the MCNZ has not considered the costs of implementing regular practice visits. The IANZ accreditation process has a dedicated body set up to support the maintenance and improvement of standards as they apply to laboratories in the New Zealand setting, including financially supporting the conduct of the site visits and travel costs for pathologists to attend. Laboratories pay substantial fees to support this process. Of note, this does not include funding the volunteer time of pathologists who undertake the peer review component of the site visits.

To expect the College to duplicate this and then also try to find pathologists on a voluntary basis to undertake more visits, taking them away from their already stretched work places, is not achievable.

6. Developing an Individualised PDP

The College does not have the resources available to do this on an individual basis and cannot support this. As stated under points 4a) and b), the College can provide a curriculum against which a Fellow can assess their own developmental needs compared to contemporary practice in their discipline. They need to further refine the areas they need to cover with reference to their scope of practice. This needs to be coupled with credentialing processes in their place of work, which is the responsibility of their employer.

7. Additional Support

The College would be prepared to offer assistance to the MCNZ in identifying pathologists at high risk of poor performance or who have demonstrated poor performance and to assist with plans for remediation where possible. Indeed the College is in the process of developing a system to identify such indivduals in line with the likely second component of the MBA's Revalidation requirements.

Thank you for the opportunity to provide feedback on this important issue. If you have any queries, please contact Dr Debra Graves, CEO at debrag@rcpa.edu.au.

Yours sincerely

Dr Bronwen Ross

Deputy CEO

8 March 2017

Ms Karen Davis
Senior Project Officer
Medical Council of New Zealand
PO BOX 10509
WELLINGTON 6143
NEW ZEALAND

Sent via email: recertificationconsultation@mcnz.org.nz

Dear Ms Davis,

Strengthening recertification for vocationally registered doctors Consultation Feedback

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) supports the development of a process that supports medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine, termed 'Recertification'. We welcome the opportunity to comment on the strengthening recertification consultation paper.

RANZCO's mission is: Improving eye healthcare through education, communication, collaboration and advocacy, nationally and internationally. Underpinning all RANZCO's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the public in all matters relating to vision and the health of the human eye and advocates for accessible ophthalmology cost effective services for patients.

We respond to each discussion question in turn below.

1. Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

   RANZCO supports the proposal in principle, but the model must be introduced appropriately with the available resources to minimise impact on patient care. The RANZCO CPD program

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already includes many of the proposed activities, however we are concerned about the detail of the model, specifically:

- How would external review be conducted? Who determines who does the review? If the practitioner decides, then there will likely be positive bias introduced into the process.
- Who measures the outcome or chooses what is measured? If the practitioner gets to choose then they would not choose to measure anything they are likely to be underperforming in. If chosen externally who will choose what is measured and how and who will enforce it?
- Who will provide the performance and outcome data, again if this is being provided by the practitioner, there is a risk of performance bias.
- If multi-source feedback (MSF) is to be used, then feedback from patients should be focused on non-technical skills such as communication, professionalism, ethics, etc.
- Consideration needs to be taken in regards to resources within Colleges and their ability to absorb this extra work into supporting practitioners through this process.

2. Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

   RANZCO has already developed a personal development plan and peer review option as part of its CPD program. At present this is a voluntary activity, which could be made compulsory for all practitioners.

3. What is your view of medical colleges defining knowledge requirements?

   Each of the Colleges, including RANZCO are responsible for developing and maintaining curriculum standards for their vocational training programs. These standards and knowledge requirements are already accredited by the Australian Medical Council and the Medical Council of New Zealand.

4. Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

   RANZCO supports the proposal, and has begun working on introducing Regular Practice Review as part of its CPD program. It is envisioned that RANZCO RPR would include:

- Service Review
  - Patient satisfaction surveys
  - Office records reviews
  - Surgical Audit and Peer Review
  - Completion of the Good Medical Practice Guide
- Personal Development Plan
  - Development Plan
  - CPD undertaken
  - Personal CPD evaluation
  - Peer review and evaluation
- Multi Source of 360° Feedback
  - Survey instrument
  - Feedback
  - Peer Review

5. Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

   In principle, RANZCO supports this concept as different practitioners will have differing needs and requirement in regards to CPD. Consideration need to be given to time and resources for each College to perform this work.

6. Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

   As per the Medical Board of Australia's recommendations, older and semi-retired doctors do not have mandatory activities that they must complete, however they are bound by the registration standard regarding recency of practice introduced in October 2016. This standard states that any medical practitioner must practice for a minimum of 4 weeks (152 hours) in any 12-month period, or 12 weeks (456 hours) in any 3-year period. All RANZCO Fellows must now complete the same CPD requirements, 80 points per annum, with a minimum of 30 points from Clinical Expertise Level 2. At this time, it is not recommended that older practitioners complete specific activities in addition to their CPD requirements.

7. Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

RANZCO continuously collects data regarding the CPD program to provide advice and support to the Fellowship and shape the CPD program accordingly. This data is used to continuously improve the RANZCO CPD offering to its Fellowship.

8. Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

   RANZCO supports this proposal in principle, as the CPD Program currently aligns to the proposed standards from the Medical Council.

9. Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?
   - Inadequate IT resources in older practices.
   - 'Winding down' practice.
   - Remote, sole practitioners
   - Lack of patient feedback.
   - Greater resource requirement for Colleges to manage CPD programs if there is a much greater compliance burden.
   - Time and cost to practitioners.

10. Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

    RANZCO's CPD program currently meets the new criteria for recertification requirements, and is confident that a three-year transition period would be achievable and appropriate.

Yours sincerely,

David Andrews
Chief Executive Officer

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24 Feb 2017

MCNZ

Response re Recertification feedback request

Thank you for asking for feedback regarding recertification. In answer to your questions:

1. We are familiar with the recent working document from Australian Health Regulatory Practitioners Agency and Medical Board of Australia on revalidation and the fairly extensive evidence base outlined in that document. We would be interested to have a summary of the evidence base for the current proposal that presents a pivotal role for the professional development plan, compared with the current CPD program requirements in New Zealand. Are there data strongly supporting a PDP in contrast to the current model of CPD in New Zealand? Clinical audit has been the most challenging aspect of CPD for our fellows to fulfil and the proposal to base a professional development plan on the result of such data could present significant challenges. Further, in specialties that are not procedural and based in the community the collection of data that might inform a PDP is much more difficult and would present considerable challenges.
2. We support the requirement for an individualised professional development plan and indeed this is already encouraged as part of our CPD program. As in our response to question one above, it would be interesting to know the data supporting the use of a professional development plan.
3. The curriculum for ACSEP training outlines the knowledge requirements for our specialty and reflects core competence domains. The ACSEP CPD program already includes expected standards of medical practice (Council Statements, and the Code of Health and Disability Services Consumer Rights) as part of its recommended CPD program. We are continuing as a college to develop cultural competence and have a working party currently focusing on this.
4. The CPD committee has regular practice review as an option for CPD in the current triennium and has developed some preliminary resources for this arm, and strongly supports its use. We would currently not have the resources to make this compulsory for our fellows.
5. The ACSEP is providing support for Fellows who are finding CPD challenging.
6. The ACSEP believes that provided a Fellow is complying with CPD/recertification requirements that they should not have any particular age dependent extra requirements. Whilst advanced age is recognised as a potential risk for underperformance the converse is that years of experience and wisdom accumulate over the course of a doctor's career and are more difficult to measure.
7. The ACSEP would be interested to know what type of data will be required for supporting continuous quality improvement. Our only data at present are the results of our random audit of Fellows for base records, and compliance data with the CPD program.
8. Our college, like many other colleges, is Australasian and it would be most helpful if the New Zealand requirements could align with Australian requirements. Our understanding is that at present the proposals in the revalidation conversation in Australia largely align with what is currently required for CPD in New Zealand and our concern is that if New Zealand changes this then we could well have a significant mismatch between the two countries recertification requirements. This would then present considerable logistic difficulties. We think that if any major change is planned this needs to be firmly based in evidence, particularly for the role of the professional development plan and for CPD to be driven by personal data. And further, that any changes should align with the MBA requirements as many Colleges are transTasman.

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9. The trans-Tasman disparity presents a significant hurdle. Conversation between AHPRA, Medical Board of Australia and Medical Council of New Zealand is critical in this regard. Medical Board of Australia in their recent working document presented a very comprehensive summary of the evidence base for revalidation and I think if MCNZ is going to make a significant change to revalidation it would be very helpful to have the evidence base and need for this summarised in a document.
10. Three years seems a very tight timeframe to affect these changes, particularly considering the flux at present in revalidation in Australia and that Australia seems to be moving to what New Zealand is currently requiring.

In summary, the ACSEP supports the use of a professional development plan, but would like to look at the evidence base that is prompting the change from the current CPD model. We have significant concerns about the ability of community based non-procedural specialities (such as Sport and Exercise physicians) to access hard data that might inform CPD if the main thrust of CPD was to hinge around such data. We also have concerns about disparity with Australian requirements and speed of change.

Thank you for the opportunity to give feedback.

Benjamin Speedy FACSEP
Chair of CPD for the Australasian College of Sport and Exercise Physicians

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual □ Group √ **Name: Dr Hugh Lees** **Position/title: Medical Director/CMA** **Organisation: BOPDHB** **Do you agree to your submission, or parts of your submission being published**: Yes √ No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes √ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I agree with this principle. **Medical Colleges should have a role in encouraging and facilitating this process.**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I agree with this proposal.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

It is appropriate for Medical Colleges to define the knowledge requirements

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I agree that RPR should be an option and at this stage should be voluntary.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Medical Colleges are appropriate bodies to provide additional support when required. Employers/DHBs may also have a role.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

This is a sensitive issue, however just as older drivers are required to undergo additional testing for a drivers licence at certain ages, it makes sense that this should also be the case for Doctors.

Ages that come to mind are 60 yrs, 65yrs, 70 yrs and annually beyond that. What would be required would depend on the scope of practise.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Continuous quality improvement should be an integral part of any recertification program. Practical requirements may need to be considered as part of this.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Standards should form a significant component for any recertification program
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
There is a variable degree of buy in to recertification and RPR processes by different groups of Practitioner, however if this is mandated by the Medical Council, then as has occurred in other Countries, then this will go some way to addressing this concern.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
3 years should fine, although those more reluctant groups will likely ask for a more gradual phase in?

Australasian College for Emergency Medicine

Australian and New Zealand College of Anaesthetists

College of Intensive Care Medicine of Australia and New Zealand

New Zealand College of Public Health Medicine

Royal Australasian College of Medical Administrators

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

The Royal College of Pathologists of Australasia

The Royal New Zealand College of General Practitioners

Royal New Zealand College of Urgent Care Physicians

Australasian College of Sport and Exercise Physicians

Council of Medical Colleges in New Zealand

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20 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
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New Zealand

By email recertificationconsultation@mcnz.org.nz

Dear Karen

Re: Strengthening **recertification for vocationally registered doctors in New Zealand**

Thank you for the opportunity to comment on the Medical Council of New Zealand's consultation on strengthening recertification of vocationally registered doctors

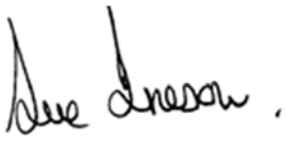
Introduction

The Council of Medical Colleges in New Zealand (CMC) is the collective voice for the Medical Colleges in New Zealand and through its members provides a well-trained and safe medical workforce serving the best interests of the New Zealand community. CMC brings together 15 member Medical Colleges who provide support to over 7000 specialist medical practitioners working in a range of 36 specialties in the New Zealand health system. The Medical Colleges advise on workforce issues and advocate for appropriate quality health services in New Zealand.

The Colleges are accredited to provide Medical Council of New Zealand recertification programmes and therefore this is an important document for the Colleges.

This submission **collates the perspectives of several of Member Colleges of CMC**, some of which will also be making their own submissions.

Yours sincerely,



Sue Ineson, Executive Director

Strengthening recertification for vocationally registered doctors in New Zealand a response from the Council of Medical Colleges

This submission **collates the perspectives of several of Member Colleges of CMC**, some of which will also be making their own submissions.

1. General Comments

In late 2015, CMC noted that there was broad support amongst the Colleges for the Medical Council vision and principles for recertification. It was noted at that time that the principles aligned well with those detailed in the Council of Medical Colleges, Best Practice Guide for Continuous Practice Improvement (the Guide). This Guide was developed by CMC with input from member Colleges and had the support of the National Chief Medical Officers Group, the Ministry of Health and the Medical Council of New Zealand.

It is accepted by CMC and the Colleges that the "profession and Council need to take the lead in providing assurance to the public and patients so that their trust and confidence in doctors is warranted" within the limitations of the Colleges' role of educational and collegial support.

The Best Practice Guide noted that the framework aimed to enable:

- Processes required by different stakeholders to not duplicate efforts or others, or lead to high compliance costs for medical specialists or be resource intensive for Colleges and employers.
- Reduction in the proliferation of new College programmes or processes by allowing the Colleges to build on what others are doing.
- Identification of and where possible, promotion of further development of, evidence-based ways to assess competence and review and provide feedback on medical specialists' performance.

Therefore Colleges, the Medical Council and where relevant employment systems should be integrated, to avoid duplication of effort and repetition of processes for different stakeholders.

CMC notes that the Colleges and the Medical Council do have different roles and powers. The Council's principal role as a regulator is to protect the health and safety of members of the public through ensuring doctors are competent and fit to practice. Conversely, the Colleges are professional bodies and educational institutes. In their educational role the Colleges provide programmes which enable specialisation and ongoing development of Fellows.

The Medical Council consultation paper does not make a clear distinction between these roles, and makes it appear that the Council is devolving its responsibility of regulation to the Colleges. The Colleges do not have the same regulatory powers as the Medical Council and College membership is not compulsory. Identifying a lack of competence and working to improve this is a core Medical Council role as outlined in the purpose of the Act.

2. Principles of any strengthen programme

There is broad College agreement that recertification programmes need to be robust and help assure the public that doctors are competent to practice. The Colleges do take their responsibility to assist their Fellows meet the Medical Council requirements seriously.

However a profession which operates on evidence needs to be assured that any current and additional requirements for recertification are able to be linked to the required outcome and that is there is some evidence that the increased Medical Council requirements will result in more competent doctors and greater public safety.

The Council's paper does not establish how the new requirements will increase competence or how they will be monitored. Adding additional requirements to recertification without robust evidence of effectiveness will lead to high compliance costs for medical specialists and be resource intensive for Colleges.

Strengthening programmes should increase effectiveness and not require large amount of additional time and resources for participants.

There have been comments that there needs to be **standards** set for some of the concepts with information on what Medical Council expects from a "constructive conversation" or a "personal development plan" or the depth of knowledge required in relation to Health and Disability Commissioners Consumer's Rights and the Medical Council's statements.

This principle was identified in the CMC guide i.e. it was noted that sector agreed standards should be set for some concepts - this standard setting role is logically the role of Medical Council. The CMC Guide did start this process and we have inserted in Appendix 1 one of those developed in the Guide. It may be useful for the Medical Council to review this and work to develop standards for matters referred to in the Medical Council's document which can then be endorsed in the sector.

3. Application of principles to all Colleges

The Medical Council seems to consider that all Colleges are alike both in resources, staff number of Fellows able to assist with the work and in types of work the specialist does, i.e. one size fits all.

Little consideration seems to have been given to the difficulty of applying additional requirements on all Colleges regardless of size or specialty. Smaller Colleges do not have the number of Fellows or staff to implement some to the proposed requirements – for example RPR systems even if applied on a voluntary basis with uptake of a few practitioners requires the same number of personal to operate and organise reviews and robust policy and processes are needed to implement an RPR even if the uptake is small.

As was noted in the Guide some branches of medicine have to take part in external quality assurance programmes and these do give evidence to help the medical specialist, along with the peers/senior, to reflect upon current practice and identify specific targets for change, the Medical Council does not seem to accept this is a form of RPR.

As the RNZCGP has argued the nature and context of general practice differs substantially from other medical specialties which are procedural-focussed and / or based in a hospital context and not

all of the requirements within the Medical Council proposal fit well within this context. This is the largest speciality in New Zealand and therefore the Medical Council needs to be cognisant of this.

In short it is Colleges' view that the current proposal goes considerably beyond the principles-based approach in terms of:

- Setting additional requirements and responsibilities for Colleges which may require considerable resourcing, may place Colleges in a difficult relationship with their members, and may open Colleges to the risk of legal action in cases where an individual member may have transgressed.
- Setting specific requirements for the activities which must be included in recertification programmes.

4. Time lines

As the Medical Council knows the development and implementation of recertification programmes by the Colleges is very resource intensive. Colleges review their programmes at regular intervals and any changes take considerable time to implement. It is also notable that bi-national Colleges must also take into account Australian work in this area. The planned three year implementation period does not allow time for the Colleges to develop new requirements while operating their current system.

5. Specific questions

Question 1:

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Performance and outcome data

Colleges do accept the importance of performance and outcome data in developing a doctor's professional development needs. Colleges support clinicians undertaking meaningful personal audit referenced to national benchmarks, where available.

In terms of outcome data, this requires the New Zealand health sector to established ways to meaningfully collect outcome data. Several Colleges have noted issues with the collection of robust and easy to obtain and use for example:

- There is a lack of registries for collecting good quality patient outcome data that doctors can use to assess their individual performance.
- Developing registries to collect data will be resource intensive for the health system, and will require careful thought about how to collect good quality, meaningful, user-friendly data as part of normal practice.
- Resource implications for management, analysis and reporting of collected data will also need to be considered.
- Medical interventions are frequently delivered by teams rather than individuals, meaning that medical outcomes are not solely dependent on one specialist.
- Patient outcome data is likely to have more utility and context in assessing and improving performance at a team and organisational level, rather than at an individual level.

- To have enough statistical power to detect performance issues, doctors would need to have a high caseload of any specific procedure for a difference in patient outcomes (e.g. mortality rates) to be shown, especially for procedures where baseline mortality rates are low.
- The caseload required for adequate statistical power to detect differences in outcomes, means outcome data is more likely to be useful for comparing performance at a team or unit level, rather than an individual level.
- For some smaller specialities, patient outcomes are rarely linked to individual performance, therefore an audit of practice is unlikely to identify or inform an individual's practice over and above existing knowledge.
- Some non- procedural specialities do not have access to data sets where a meta-analysis is undertaken of nation-wide patient outcomes therefore it would challenge to implement this component into a recertification programme. It may be possible to analyse the data collected by PHARMAC to benchmark prescribing behaviour but this is but one part of a doctor's professional practice.

Therefore it is unlikely many doctors will be able to identify their individual CPD needs based on patient outcome data at this stage. Mandating action on outcome data where it may be of poor or meaningless quality may result in unintended consequence of risk to patient quality of care.

In terms of patient outcome data, it is noted that the Ombudsman's June 2016 Official Information Act opinion about surgical outcome data recommends that the Ministry of Health and the Health Quality and Safety Commission lead health sector work on collecting outcome data that "is meaningful to health care consumers; is meaningful to the clinicians who provide their care; are meaningfully attributable to the clinicians or service providing that care; and increase the availability of information to the people of New Zealand."

CMC supports the sector taking a broad, strategic approach to establishing how patient outcome data can be meaningfully collected and utilised for quality improvement. This would be more effective than individual Colleges attempting to address this issue in a short timeframe as part of individual CPD programmes.

Once the New Zealand health sector has established ways to meaningfully collect outcome data, Colleges would support clinicians undertaking meaningful personal audit referenced to national benchmarks, where available.

CMC suggests that the Medical Council does not forward this principle until after the above work is done.

Multi source and properly informed peer feedback

Most Colleges accept multi source and properly informed peer feedback is useful and evidence collected when CMC was developing the Guide note that this can enable the medical specialist to reflect on their performance as seen by others.

However medical specialists in some settings do find it more difficult to organise multi source and effective external peer feedback.

The RNZCGP has noted particular concerns with both multisource feedback and peer review as defined by the Medical Council, in small communities. Specifically with regard to the use of the colleague feedback tool, the College is concerned that:

- There is potential for adverse consequences on collegiality in small regions if negative comments are received.
- Survey fatigue will result if the MSF tool was required to be used regularly by all doctors. Particularly in rural areas and small towns, people are likely to be selected as survey respondents multiple times.
- This tool will also be difficult to use for those doctors working in a non-traditional settings.

And in terms of peer review the RNZCGP while considering peer review as very valuable – note as it currently operates it may not meet Medical Council requirements.

It would also be useful for Medical Council to define criteria around peer review and whether this does have to be external and what this actually means for employed medical specialists and for those in partnerships with colleagues.

Constructive conversations

The CMC Guide also does support individual "conversations" based on information derived from actual practice – through activity analysis, practice visits, observation of work and reports of external quality assurance programmes.

Some Colleges have already developed tools to guide the constructive conversations that follow the gathering of multi source or peer feedback .If areas of weakness are identified it is accepted there must be a College process for assisting the medical specialist to identify and address these though future learning when there is a low level deficiency. Dealing with substantial concerns about competence is the role of the Medical Council.

It is noted that for those employed assisting identify and remedy weaknesses is not the sole responsibility of the College.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and those doctors will be expected to review their own PDP each year?

Personal development plan

Most colleges support the proposal that vocationally registered doctors should develop a professional development plan that identifies their professional development needs, it is accepted this will help tailor CPD activities to the learning needs of the individual which can be reviewed regularly to ensure achievement and relevancy. PDP can be very useful to assist reflection on past progress (or otherwise) and plan CPD activities and audits for the next 1-3 years.

Developing and reviewing PDPs should also fit well with employer performance appraisal processes.

Some Colleges already require participants to develop a PDP plan as part of CPD and provide guidance on how to identify learning needs. Some Colleges will need to develop additional mechanisms to analyse PDPs and feed back to doctors on whether an individual's PDP is adequate or not. This will require resources.

CMC considers it reasonable that doctors' PDPs should be informed by data from audit, multisource feedback, and peer review. It is accepted if minor areas of weakness are identified there must be a process for assisting the medical specialist to identify and address these though future learning, using a professional development plan. Though there are others should be able to assist with this especially if the doctor is employed.

However as noted above in terms of defining standards for elements needed in a PDP it would be useful for the Medical Council, given the broad underlying similarities within scopes of practice, define a standard about what activities and goals are desirable within any PDP which should then be balanced against individual differences and needs.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Professional competence of medical practitioners is a complex construct. It has been defined as *the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served.*[1] Medical specialists need to demonstrate both clinical competence (technical skills and knowledge) and behavioural competence (interpersonal and affective skills, such as the ability to communicate effectively, use judgment and empathy and manage relationships) in their daily tasks.[2]

Professional competence, however, is not a collection of isolated competencies. Knowledge, skills and behaviours are integrated into a whole, enabling doctors to use expert scientific, clinical and humanistic judgment to engage in clinical reasoning and respond accordingly. They need to be able to manage ambiguous problems, tolerate uncertainty, and make decisions with limited information,[3] often in emotionally fraught situations.

In terms of the specific documents mentioned such as the Health and Disability Commissioner's Consumer's Rights, and the Medical Council's statements, there would be merit in the Medical Council taking a national approach to defining the knowledge requirements for these documents. This is because the knowledge requirements for the legislative framework that governs health practitioners should be consistent across vocational scopes. It is an unnecessary duplication for each College to identify the required knowledge base, and orchestrate assessment tools independently. . Such an approach might benefit from collaboration with the Council of Medical Colleges in a continuation of the collaboration which produced the Guide.

[1] Epstein RM, Hundert EM. Defining and assessing professional competence. JAMA 2002; 287: 226-235.
[2] Dubinsky I, Jennings K, Greengarten M, Brans A. 360-degree physician performance assessment. *Healthcare Quarterly* 2010; 13: 71-76.
[3] Epstein and Hundert, *op. cit.*

It is also noted that the Medical Council also has a lever available to ensuring all doctors familiarise themselves with legislative requirements, by potentially making it part of the requirements for renewing annual practising certificates to indicate they have read and considered the Code and Medical Council statements. Some other registering authorities do, at APC time, ask their practitioners to sign that they are familiar with codes or standards – this at the very least brings the documents to the attention of practitioners.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Some Colleges such as RANZCOG have been performing RPR visits for some time and doctors have found them to be a useful experience. Therefore while some medical specialists do accept that RPR is a useful process to ensure competence, others do not. All agree it is a resource and time intensive process.

It is accepted that a form of practice review is very useful if there are doubts about a medical specialist's competence. The Australian Medical Board revalidation proposals makes it clear that there is a difference between setting up a system to ensure most doctors develop and improve competence and setting up systems to identify and work with the very small minority of doctors who are not competent.

To make RPR option available even if only to a few practitioners, the College will have to develop full systems to deliver a robust RPR. In addition in Colleges where there are only a limited number of specialists finding Fellows available for RPR will be a challenge. Also for Colleges with limited staff resource in New Zealand this will be a large administrative burden.

Overall Colleges are not convinced an RPR system is this the best use of limited sector resources? Has any assessment made of the risks to the public and if RPR will reduce these risks? Because RPR is resource intensive, it is essential to demonstrate that RPR achieves measurable benefits in terms of practitioner performance, and patient safety. Simply identifying that an individual found the process engaging, and intends practice change, of itself is poor evidence of worth. The value judgment required to justify such use of time needs to be robust when applied to a resource constrained healthcare system.

As noted above standards or definitions are needed for the frequency anticipated by "regular" and the definition of "external".

In terms of Regular Practice Review (RPR) specifically, a College has noted that it is unclear from this proposal whether medical colleges would be expected to provide tools to assist with RPR, or to actually perform RPR's. Based on the principles outlined in the Medical Council's RPR policy, achieving quality RPR is time consuming for both the assessor and the individual being assessed. Although at this point the Medical Council is suggesting voluntary RPR, it will still be important to consider what impact a large uptake in RPR would have for the health sector, and how this would be resourced.

One College has suggested that the Medical Council uses the CMC best practice guide to adjust its RPR policy, broadening its definition of practice review, thereby reducing duplication. Such an approach may make RPR more feasible, cost-effective and time-efficient.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Some Colleges have been developed systems for collegial support however support given by a College is only one avenue open to a doctor needing assistance especially if she or he is employed. The premise of many of concepts being promoted – seems to assume "one size fits all" and does not take into account the need to adapt requirements to the situation to reduce duplication of effort as suggested in the CMC Best Practice Guide.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctor's age? If so, what activities and what age should apply?

Age is not an indicator of competence – mandating certain activities at certain ages will be counterproductive. Ageing alone is not the only reason to revisit workload, hours and case-mix. Social and health issues can affect performance at any age. We believe mandating specific CPD activities for older doctors will not sit well with the Human Rights Act 1993 that prohibits discrimination based on a person's age and the Human Rights Commissioner who is encouraging employers to employ older people and develop a culture where older people are valued.

While there are studies supporting a general decline of cognitive function and competence as doctors' age, this is not a universal finding and should not be used to tar all senior doctors with a "potentially incompetent" brush. Encouraging the proactive self-reporting to colleges of significant health conditions is a positive approach. Retrospective interventions and support from colleges once concerns have been identified is a more appropriate interventionist strategy in assisting older doctors with career planning

If the MCNZ is seeking to identify at risk doctors and direct them towards particular CPD activities then we suggest they focus on those doctors who work in isolation and those who are '" *frequent flyer" doctors who attract a disproportionate share of complaints'*[4] Studies in Australia have noted that 3% of all doctors accounted for 49% of all complaints therefore it suggests that a small group of doctors are responsible for poor outcomes [5]Paterson notes 'there *is clearly a need to do so in this context. Indeed, the fact repeat offenders can continue unchecked indicates a failure of colleagues, employers and regulators to respond satisfactorily—a different kind of 'system' problem'* . In order to protect the public and reduce harm, which are the key underlying principles of the Health Practitioners Competence and Assurance Act 2003, it would

[4] Paterson R(2013) Not so random: patient complaints and 'frequent flier' doctors. *Quality and Safety in Health Care 2013, 10 April 2013 BMJ online*

[5] Bismark MM, Spittal MJ, Gurrin LC, et al (2013). Identification of doctors at risk of recurrent complaints: a national study of health care complaints in Australia. Quality and Safety in Health Care 2013, 10 April 2013 BMJ online

be a useful investment of resources to concentrate on improving the practice of the "frequent flyer" doctor. Targeting these doctors and developing specific CPD activities for this group may contribute to greater improvements in quality of care.

We would advocate for a greater emphasis on working more closely with those practitioners who practice in geographical or professional isolation as it is often difficult for these doctors to participate in CPD activities such as peer review groups due to their geographical location and/ work commitments. The Royal College of Physicians has outlined clearly the challenges facing the isolated practitioner in the New Zealand situation [6]

We would also argue that CPD activities need to include some reference to the doctor's health and identification of those CPD activities that might contribute to addressing potential challenges in a doctor's practice. The General Medical College has included information regarding the individual doctor's health status in their revalidation process and we suggest that the MCNZ could investigate how doctors' health might be addressed with particular CPD activities.

We do note that HWNZ is producing a report with advice both on the aging doctor and how to deal with issues of career management, career planning and career change throughout a doctor's life. We suggest the Medical Council continues to work with HWNZ on this rather than place additional requirements on Colleges.

Question 7

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

It is agreed that it is good practice to evaluate recertification programmes and support continuous quality improvement. However Colleges will need guidance on what data has been shown nationally or internationally to be effective.

There is concern that this would be a time consuming and difficult task particularly for a small College who have limited resources. While the continuous quality improvement is an important tenant of good medical practice, quality improvement is more usually systems based. Such processes are best driven supported and analysed in the work environment, rather than a College level.

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

See above CMC has argued that Medical Council of New Zealand should provide more detail on standards expected.

Question 9:

[6] Royal Australasian College of Physicians (2015) Physicians and paediatricians practising in isolation in New Zealand.

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The Colleges are of varying sizes – both in number of Fellows and in terms of the number of staff they are able to employ. Time and resources are limited – a slower change would enable Colleges to adapt. Three years is not a long time to implement a major change especially in Australasian Colleges who will also be working to accommodate AMB changes.

As noted above some matters such as standard setting or developing methods evaluation of programmes is a role that could be done once by the Medical Council and then applied to all, rather than each individual College tackling the issues?

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for? Implementation of new recertification requirements?

Time and resources are limited – a slower change would enable Colleges to adapt.

This submission is on behalf of: Individual □ Group ☑
Name: Sue Ineson
Position/title: Executive Director
Organisation: The Council of Medical Colleges in New Zealand
Please note that this submission collates the perspectives of several of Member Colleges of CMC however it has not been possible to get one agreed consensus view of the Colleges in the time available.

Appendix 1.

Standard for the Constructive Conversation

All those Colleges who currently run a form of practice visit or RPR, and those employers involved in interview /performance appraisal processes, note that the "conversation" the doctor has with peers (RPR) or senior (PA) or a colleague (PR) is the element that adds most value. In practice this process has been shown to lift the performance of the doctor being reviewed and it also assists the learning of those involved in the review or appraisal.

Such a conversation may thus occur:

- In a practice visit
- As part of a performance appraisal
- In a credentialing process
- In a peer review process
- In a practice discussion
- Following an external QA review.

It is the opportunity for the doctor to receive constructive feedback, to reflect on his/her learning, to identify areas for development and to begin to put them together into a professional development plan. It also may give him/her the opportunity to explore their satisfaction in their current role, self care, any health issues and to set performance targets for the future as well as longer-term career aspirations.

Regardless of the setting, the constructive conversation should:

- Be structured and take place in a setting conducive for in-depth discussion.
- Focus on the positive
- Emphasises the future
- Be informed by actual evidence
- Encourage self reflection
- Give specific suggestions for development
- Be lead by a trained senior or peer
- Not be focused on matters such as terms and conditions and departmental issues

23 March 2017

Karen Davis
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WELLINGTON 6011

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Dear Karen

Proposal – Strengthening certification for casual registered doctors

Thank you for requesting comments on the proposal on strengthening certification for vocationally registered doctors in New Zealand. Several Senior Medical Officers from Hutt Valley DHB have forwarded their individual responses to your proposal. The answers to your questions are as follows:

Question 1

We agree in principle that doctors would need to use performance and outcome data and multisource feedback data to identify their professional development needs. However, accuracy of current health data and adjustment to case mix may make them difficult to interpret.

External peer review would be valuable if there is the right environment and appropriate support structure for peer/clinical practice review. An external review may be relevant to smaller services with one or two doctors. For most of our departments external peer review of individual doctors could be an expensive exercise with limited value.

Some outcome data should be used to develop professional development plans. It is helpful if professional medical colleges could develop systems to support this process. Having such a system is important in delivering high quality outcomes and improving patient safety and care.

Question 2

I do not believe digitalised PDP for each doctor should be the central part of re-certification but it should play an important part. I agree that PDP could be reviewed each year as part of the annual appraisal. It is useful to link re-certification with the DHB appraisal process to avoid duplication.

Question 3

Professional Colleges could define the knowledge requirements but this could be reasonably broad based for generalists and challenging to administer. For instance, core knowledge requirements for a general physician practicing in a tertiary centre may differ from what is required for a smaller hospital. Knowledge requirement for an interventional cardiologist could be easier to define.

Question 4

Regular practice review is appropriate as a voluntary option. This is a valuable tool for DHB if there are concerns about an individual doctor's clinical practice.

Question 5

Colleges could provide additional support for doctors when required. How would colleges find the time for volunteers to take part in this activity other than developing electronic aids? Colleges are heavily reliant on voluntary work by the fellows and if this is going ahead it could cause an additional burden to the health system. A balance needs to be found and it would be better to give several options including electronic aids to suit this situation.

Question 6

Career management planning is useful but whether the Medical Council is best judged to lead this is debateable? This could be a joint activity between DHB and the College. Chronological age is a problem as some people might develop problems prior to retirement age. As a guide, when doctors reach 62 years it may be reasonable to encourage them to consider this option.

Question 7

Continuous quality improvement is absolutely necessary for re-evaluation and re-certification activities. However, if people are not familiar with these concepts the appropriate education needs to be provided. Some specialities are reliant on automatically generated data to monitor quality rather than quality improvement. Several DHBs are investing in up skilling staff in improvement science. Again, some regular workshops from the medical colleges on improvement science and use of audit activities and data for continuous improvement would help in changing the landscape from quality assurance to continuous quality improvement. Traditionally professional colleges have focussed on quality assurance and this focus should change to quality improvement.

Question 8

I think the direction is correct but this needs to be carefully planned to avoid duplication so that all parties concerned get value out of the re-certification. Having separate processes for DHBs, council and colleges is problematic and if all processes could be aligned it would be a "win win" for the health system. Re-examination of knowledge is of little value, quality improvement and peer review are appropriate but in a group settling this can be handled in house, 360 is an option as required, but regularly be used every 5 years, colleges have a key role and completion of requirements should meet council expectations.

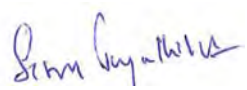
Question 9

Key barriers would be the cost as there may be more peer review type of activities and an extra burden placed on the colleges and the volunteers. These needs to be a balance against value for money proposition, given some DHBs might be able to do this internally. There may be issues in relation to small general practices with isolated single practitioners.

Question 10

I think three years may be a reasonable period but unless it is implemented well, there will be a lot of additional work without much gain. The planned timeframe is reasonable provided we can all come to an agreed conclusion about what is the best way to work this through. Perhaps incremental steps of introducing the change would be more appropriate.

Yours sincerely



Dr Sisira Jayathissa
Chief Medical Officer
Hutt Valley District Health Board

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐ **Name:** **Position/title:** **Organisation:** **Do you agree to your submission, or parts of your submission being published**: Yes ✓☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
We agree that in some areas performance and outcome data should be used to inform professional development plans. Unfortunately most of the data collected within the hospital system is financial-based data and has very poor correlation to quality and patient outcomes. Collecting and collating such data could generate a significant workload for clinicians so the performance and outcome data collected must be easily obtainable by clinicians and systems put in place within the DHBs to facilitate such collection. **There is also the risk that recording mandatory outcome data could have the effect of narrowing the focus of CPD activities rather than focussing on individual development needs.**

Some Medical Colleges do have requirements for patient satisfaction surveys and audit as part their continuing professional development. I believe that this is appropriate than it is for Medical Colleges to assess doctors with performance outcome data measurements.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

An Individualised Performance Development Plan for each doctor should be a central part of recertification. Key to this being formative is individuals are NOT left to complete this in isolation. Often opportunities for areas of development are missed without constructive feedback and reflection. Those most likely to benefit are often those individuals whose performance is lower than acceptable and such individuals are likely to either not recognise this or feel uncomfortable in admitting an area of deficit.

Peer or Senior Review of a professional development plan would enable it to be more objective.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Each medical college is ideally positioned to define specific knowledge requirements for their vocational scope. It is entirely appropriate that they continue to define this knowledge as part of their ongoing CPD programmes. It is essential to acknowledged that requirements may be different between in different areas so thought should be given to how requirements can be contextualised and localised.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

If the Medical Colleges are required to develop a programme for regular practice review then it is important that this is undertaken within a framework defined by the Medical Council. As a tool regular practice review is invaluable, particularly in specialties where individuals practice in relative isolation. It offers benefit, both to those being reviewed and the reviewers. Consideration should be given to making a practice review mandatory for any given timeframe, but annually is probably too frequent.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Colleges should be willing to provide additional support for doctors on their individual needs. Referring back to the previous statement, it is important that the development needs are clearly identified in the Professional Development Plan, and this should involve discussion between the professional and a peer or senior. Of necessity is the involvement of the local employer in this framework.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Yes the Council should mandate that career planning should occur and the plan reviewed on a yearly basis with each annual review and there should be discussion about the annual professional development plans and the five year long-term development plan.

More specifically above the age of 55 a plan should be made around on-call commitments and retirement planning.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This should be mandatory.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

It is entirely appropriate that the Council sets standards for recertification programmes. There needs to be some standardisation with minimum requirements for recertification and this should be set by the Medical Council.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Most of the Colleges are Australasian based and therefore will have different requirements from the NZ Medical Council and the Australian Medical Council. Getting alignment across all of the Colleges and both Councils will be a significant challenge. The only possible solution is agreement between the Australasian Medical Council and MCNZ around the minimum requirements for the recertification model.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes.

Nelson Marlborough Health
TE WAIORA

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22nd March 2017

Karen Davis
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Dear Karen

Response to Medical Council NZ Consultation Document on Strengthening Recertification for the Vocationally Registered Doctors

Thank you for the opportunity to comment on your consultation document and for the extension of time you have provided.

We see recertification as a key pillar within the clinical governance systems of health services within New Zealand. It is vitally important that it does not develop in isolation separated from other clinical governance processes.

Recertification needs to be a process with high levels of sensitivity and specificity which has the potential to prevent problems, guide professional development and identify and address deviations from good practice early. All sources of information are therefore needed to be drawn on and linked. The process must not to be blinkered with reduced sensitivity because of missed opportunities to gather information.

With these opening comments in mind, the continued move away from just recording learning opportunities is applauded and this change needs to continue. Vocationally registered doctors work in teams that contain other doctors and colleagues from many disciplines. The proposal put strong emphasis on the role of the colleges but makes no mention of the role of the employer. The colleges will never have the resources to get a clear understanding of locality team relationships and planning. On the other hand for the employer this is their core business. Even for those involved in private practice there should be a team and some organisation with responsibilities to ensure that local care delivery is of high quality. Responsibility either from a public or private provider typically comes under the heading of credentialing as required by the Ministry of Health.

Good employers also get involved in regular performance appraisals to help health professionals provide quality services, review what has been going well, what has not being going well and plan for the future. It also provides an opportunity to address other goals highlighted in your consultation document around supporting an aging workforce, succession planning, team work, collaboration, communication, management and professionalism.

We believe to get the best use of health resources as well as maintain the highest quality of care, maintenance of professional standards and performance the three processes: recertification, credentialing and performance appraisal, should be intimately linked. This also avoids subjecting

doctors to multiple jeopardy and avoids waste resources that can arise through duplication of process with failure to share information.

Each of these three processes: recertification, credentialing and performance appraisal has specific strength that should be drawn on. For example the colleges bring national and frequently an Australasian perspective on contemporary practices as well as the domains of knowledge required. Credentialing focusses on care delivery within the domain of the employer and wider team performance and resourcing. Performance appraisal looks at the details of professional care relationships and future career development. The domains indicated in your document cross over all three of these areas. The future direction looks very sensible with the development of 360^{o} feedback, the professional development plan and career planning phases.

In my work as a Chief Medical Officer I am exposed to a small number of doctors for whom performance concerns arise. I am not aware of any cases where college requirements have resulted in performance concerns being highlighted. This may be because a College would not tell me or they are so removed from the cold face they do not have the sensitivity to identify issues.

To consider answers to your specific questions:

1. The performance and outcome data, multi-source feedback and external peer review information set is very important and should certainly be used to guide recertification. A very similar information set is collected by an organisation that is doing effective credentialing and performance appraisals. This information collection should be done well, in one place and collated and then used with the different lenses required for the three difference processes. The role of the college in this would be to specifically look at the facets of this information set where the college has the greatest skills. Typically around speciality specific elements and contemporary practice which colleges could also have a role in supporting doctors in providing the templates to connect the information that is speciality specific.

2. The development of an individualised professional development plan is very important and is a central part of recertification; it is also a central part of performance appraisal management. Reviewing this annually seems a very good idea, Nelson Marlborough Health currently is rolling out a work planning process that leads to a discussion annually between the head of department and service manager for each senior medical officer and their professional development plan elements are a part of this discussion. Also included is looking at goals for the coming year with regard to conferences and sabbaticals as well as specific tasks and then reviewing the completion of these tasks on the subsequent work planning process. For Nelson Marlborough Health the work planning process is considered performance appraisal.

3. The medical colleges are very well positioned to define knowledge requirements for things about which the college has knowledge. Particularly around aspects of contemporary practice within the specifics of the speciality. The college is not however, well placed to look at all the council domains of competence and it cannot be expected that this process alone can achieve that.

4. Opportunities for regular practice review are important and it is good that each college has a system by which this can be provided. It is important that regular practice review is incorporated in the functioning of a good department as business as usual, rather than an exceptional event that people get ready for do and then leave behind them. Nelson Marlborough Health has developed a checklist of a department where clinical excellence is likely to flourish. Departments that are implementing this checklist well have developed process where there is constant review of practice.

5. Providing additional support for doctors is the responsibility of a good employer. Support should be based on individual professional development needs. It would seem unlikely that medical colleges will ever be resourced to be in a position to do this to every senior medical officer within their college. Input therefore should be targeted to those with the greatest ability

to benefit and the greatest need and should be seen as an add-on to the responsibilities and routine work of a good employer within their clinical governance systems.

6. It is very hard for the council to mandate certain activities as doctor's age. Nelson Marlborough Health the purpose of the work plan is to regularly touch base with doctors to see where areas of challenge is arriving and also consider succession planning and managing the aging workforce. This can often be done well within the context of a high functioning department where there are members of the team who bring high levels of experience and wisdom while other aspects of practice require support from younger colleagues.

7. The national and international overview that a college can provide is likely to be highly beneficial to employers as they undertake recertification. A college can highlight the themes where performance may be falling below acceptable standards, themes that emerge from new technologies and changes in practice typically be highly speciality based and so the college is best placed to support others in providing the framework to seek out these challenges rather than having to discover them for themselves.

   The college may also have an important role in collecting information around unwarranted variation within and across services which can lead to continuous quality improvement.

8. As outlined in the preamble to this letter it is very important that the recertification process is considered as one of the pillars within a strong clinical governance system. It should not be considered in isolation.

9. Barriers exist in terms of the proposal as colleges are too far from the coal face to provide the detail required for high quality recertification. An obvious solution is to look at the clinical governance structure required for healthcare and let each element in that structure plan to their strengths while remaining linked. In this instance, employers engage with the whole of the health team and are therefore best placed to support the professional development of that team. Colleges engage with a speciality issue and therefore have the greater depth of knowledge in that area.

10. Three years is a realistic timeframe for many of the changes but I would suggest that this should be a step-wise change that occurs over the next 12 years each year bring a small amounts of change so the workforce grows change competence and the process gradually transformed into a high functioning system.

Yours sincerely

Dr Nick Baker, BSc, MBChB, DCH, FRACP
Chief Medical Officer
Nelson Marlborough Health
nick.baker@nmdhb.govt.nz

Cc recertificationconsultation@MCNZ.org.nz

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Group [redacted] **Do you agree to your submission, or parts of your submission being published**: No **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Not sure how the doctor will put the performance and outcome data together. Although this is available routinely in the DHB there may be pressure to develop new measures and current access is low. It is unlikely medical colleges will have the resources to provide much practical support around the country.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

While developing a PDP will be useful, more use would be if it was reviewed in conjunction with a senior colleague in order to guide and support practice. Systems are not well developed for this to occur and it will further impinge on clinical time.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Many of them will struggle and they will have difficulty in defining the aspects of practice relevant in work settings such as [redacted]. Here the cultural context is vitally important and unlikely to be well captured or translated to PDPs.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Should be required, not an option. Who will fund the RPR?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This also seems unlikely to occur from colleges. Given the types of issues discussed it is more likely the expectation will be on the employer to support this, as occurs now, and the input of colleges or the MCNZ will be minimal.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

These principles are relevant at any age owing to differing pressures on clinical performance. There shouldn't be a particular change at any age but a requirement to have career management at all ages.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

What data would Colleges actually collect and how would they ensure accuracy to enable decision making on the information gained? How would information be reported? Who would supply it to the colleges? Individuals or employers?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Council needs to put greater emphasis in recertification on cultural competency and the development of this including responsiveness to people factors in care. This can come through patient feedback and colleague assessment but the colleagues must include those best able to assess and provide developmental feedback on these matters.

How will non-compliance be addressed? Or sub-standard compliance, along with sub-standard performance?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Doctors finding time to complete the tasks or those charged with having the conversations finding the time including matching that with a time the reviewee is available. Further deterioration in the availability of clinical time.

Hone down the requirements. Base as much as possible on electronic filing. Reduce the conversations: while they may be ideal they are unlikely to happen anyway.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Probably but depends on what is finally decided.

Antonia O'leary

From: Tom Watson <Tom.Watson@waikatodhb.health.nz>
Sent: Tuesday, 21 March 2017 4:58 p.m.
To: Karen Davis
Subject: RE: MCNZ consultation on recertification

Hi Karen,
Very happy with the document [it will need a little tweecking].
Tom

From: KDavis@mcnz.org.nz [mailto:KDavis@mcnz.org.nz]
Sent: Tuesday, 21 March 2017 16:04
To: Tom Watson
Subject: MCNZ consultation on recertification

Dear Tom

We have noticed that we have not received a submission from Waikato DHB in response to the Medical Council's recent consultation about recertification requirements for vocationally registered doctors. Your feedback is important to us. We can extend the deadline to close of business Monday 27 March. Please let us know if you or your Chief Executive intend to make a submission. You can find the consultation paper on the following link https://www.mcnz.org.nz/news-and-publications/consultations/consultation-on-strengthening-recertification-for-vocationally-registered-doctors/

Your feedback can be emailed to recertificationconsultation@mcnz.org.nz

Kind regards

Karen

Karen Davis | Senior Project Manager
Te Kaunihera Rata o Aotearoa - Medical Council of New Zealand

Level 6, 80 The Terrace | Wellington 6011 | PO Box 10509 | The Terrace | Wellington 6143 | 0800 286 801 | Email kdavis@mcnz.org.nz

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Waitemata
District Health Board

Best Care for Everyone

Chief Medical Officer
Private Bag 93-503
Takapuna
Auckland 0740
Telephone:09 442 7203
Facsimile: 09 486.8924

15 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
NEW ZEALAND
Sent via email to recertificationconsultation@mcnz.org.nz

Re: Waitemata DHB Submission to the Medical Council of New Zealand's Consultation, Strengthening Recertification for Vocationally Registered Doctors

Dear Ms Davis

Thank you for the opportunity to provide feedback on the Medical Council's proposal for strengthening recertification requirements for vocationally registered doctors. Please find below summary points of our response followed by more detailed information based on the set of guiding questions provided by Council.

Summary

- The implementation of the recertification requirements as proposed, especially the use of a targeted and personalised professional development plan is generally supported.
- There is potential benefit that achievement of goals from individualised PDPs can assist with credentialling and scope of clinical practice for individual vocationally registered doctors at the DHB in which they work.
- Although recertification is profession-led and this model is supported, more emphasis should be given to incorporate the employment context of a vocationally registered doctor's scope of clinical practice within their workplace setting when developed annual personalised development plans (PDPs). Medical colleges will not have detailed awareness of individual doctors functioning with their workplace setting although the proposal has them almost solely responsible for managing and monitoring PDP development and achievement.
- Meaningful individual practice outcome data is difficult to obtain within a DHB, although the information systems are trying to move to support such data being available. It is unknown ether the data medical colleges may require is feasibly able to be produced by DHBS.
- Organisations have a responsibility for annual reviews, and credentialing processes. Multiple annual employee processes would be problematic and not practical as doctor time and resources to support these are limited, so organisations would need to find a way in integrating all these requirements.
- Consideration of the direct impact of new recertification requirements on DHB resources should be considered, particularly any support required providing doctors with good quality performance and outcome data generated by their duties within a DHB and within the context that personalised PDPs may lead to a much greater variety of data sources needing to be acquired.

- The new proposed requirements will likely lead to increased costs and resources by medical colleges as they support development, implementation and ongoing monitoring of recertification requirements. However, if these costs are passed on from the medical college to doctors, current contractual arrangements will mean these costs will ultimately be incurred by DHBs (for DHB employed doctors) and this effect needs to be considered before a final.

Thank you for the opportunity to comment.

Yours sincerely

Dr Andrew Brant
Chief Medical Officer
WAITEMATA DISTRICT HEALTH BOARD

Dr Paul Muir
RACMA fellow
WAITEMATA DISTRICT HEALTH BOARD

Enc: Submission information

Submission information

This submission is on behalf of:

Name: Dr Andrew Brant (CMO) and Dr Paul Muir RACMA fellow
Position/title: Chief Medical Officer
Organisation: Waitemata DHB
Do you agree to your submission, or parts of your submission being published: Yes X No
Do you agree to all or parts of your submission being published if it was anonymised: Yes X No

Guiding Questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based, on a set of requirements, including use of performance and outcome data to identify individual professional development needs.
Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Response: We are supportive of the use of performance and outcome data that supports the development of a targeted professional development plan for individual vocationally registered doctors, provided the data is of good quality and applicable directly to performance of the those doctors without interference from other contextual factors outside their control (such as organisational factors or degree of clinical resources available to the doctor). It is worth noting that DHBs providing meaningful outcome data of clinical practice is challenging, although for our DHB we have set a path for our information systems to provide this data. Currently within our DHB outcome data is driven by the clinicians themselves about what is clinically meaningful to them, so this may drive different outcome measures from which the colleges suggest. Also we don't know at this stage whether the DHBs would be able to provide these measures. It may be best for broad categories of outcomes to be developed which local services/DHBs could provide tailored outcome measures

Medical colleges assisting vocationally registered doctors would likely provide consistency for all doctors in that specialty in both the applicability of specific types of performance and outcome data and their interpretation on the development of PDPs. Qualitative information in a reflective context, such as multisource feedback from colleagues and patients is also supported.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.
Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and those doctors will be expected to review their own PDP each year?

Response: We are supportive of the use of a personalised PDP for doctors that is reviewed annually and that this is a central part of recertification. Practical guidance or support for both vocationally registered doctors and their employers on monitoring the achievement of PDP goals throughout the year would be helpful to ensure vocationally registered doctors are continually improving in their professional development and actually achieving all or most goals in their PDPs each year.

From an organisational point of view we would need to further integrate this with the annual reviews, which are organisational requirements. Duplication (along with credentialing requirements) would be very problematic, as probably only one process incorporating the accreditation process, organizational review, and potential credentialing could be sustained

In certain circumstances, achievement of individualised PDP goals for recertification may also assist vocationally registered doctors in employer related credentialling and scope of clinical practice reviews and is supported.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence3, cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.
Question 3:
What is your view of medical colleges defining knowledge requirements?

Response: Individual medical colleges are probably best placed in defining knowledge requirements for vocationally registered doctors in their specialty and that reflect expected standards of medical practice. This would also be in keeping with a profession-led approach to recertification.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.
Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Response: Regular Practice Review (RPR) is likely to beneficial for at least some vocationally doctors and can provide information for the doctor to support the development of areas to concentrate on for their PDP plan. Each medical college will need to clearly define the components of a RPR model applicable to their specialty with possible review by Medical Council to ensure the expected standard of a RPR model between different medical colleges is maintained and broadly equitable between doctors of different medical specialties.

Resources and costs involved in Regular Practice Review (RPR) for doctors would need to be considered. Any costs and resources incurred by medical colleges in development and delivery of a RPR model would likely be reflected in increased College fees and in the case of DHB employed doctors, contractual arrangements will mean this increased cost will ultimately be covered by DHBs. Depending on the extent of a RPR model, these costs may be significant for DHBs.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.
Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Response: Support for an individual doctors' professional development plan needs to be seen within a wider context than just their medical college. It is important that the doctor, their medical college and their employer all have input in a collaborative way to help guide career progression and work requirements and monitor factors that can influence doctor performance.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Response: Career management planning is important. Consideration of alterations to case mix or hours/shifts work would have implications on service delivery and so would need to be seen within the wider context of the service in which the doctor works and the scope of clinical practice of other doctors that they directly work with. We are unsure that mandating of certain activities at a certain age of a doctor is warranted but broader issues related to career management such as transition to retirement, service planning and succession planning are important and are supported.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement
Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Response: Continuous quality improvement of recertification programs is important and supported. There should be guidance given to medical colleges about the extent of both collection and analysing of data to guide evaluation and improvement of any recertification programme. Such activities need to be robust enough to guide recertification programme improvement but not overly cumbersome that there is diminishing value from resource input. Again, any costs and resources incurred by medical colleges to support this may be passed on to DHBs (for DHB employed doctors) and this effect needs to be considered.

General Questions
Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

Response: We are generally supportive of professional development plans that are personalised for individual vocationally registered doctors. More emphasis on developing a PDP based on the context of a vocationally registered doctors specific workplace setting and current scope of clinical practice would be beneficial to ensure improvements in knowledge and performance through a PDP are directly aligned to day-to-day practice rather than just theoretical interests. The context of a workplace setting aligns with the Council's vision and principles for recertification but then relies heavily on medical colleges to support and manage the doctor in meeting their PDP requirements. A medical college may not have intimate detail and functioning of each individual doctor within their workplace setting.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Response: Barriers to implementation of the proposed recertification model could include the level of support that needs to be provided by individual DHBs in providing good quality performance and outcome data for vocationally registered doctors, especially in the context of personalised PDPs where

the type and content of data would vary between individual vocationally registered doctors. Guidance from medical colleges to doctors may be helpful to guide doctors with the level of performance and outcome data required for PDPs without placing excessive or unnecessary reliance on DHB resources.

Another barrier is the duplication of effort of accreditation, organisational annual review, and credentialing requirements, and best that they can be all aligned to one process.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Response: This timeframe seems appropriate provided there is contingency for adjustment if genuinely needed by medical colleges and DHBs in terms of resources required to ensure the recertification programme if fully functional. A three year transition period should be ample time for individual vocationally registered doctors to become familiar with any new requirements.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual □ Group ✓ **Name: Louise Torr** **Position/title: Business Manager; Medical Management Unit** **Organisation: Whanganui DHB** **Do you agree to your submission, or parts of your submission being published**: Yes ■ No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ■ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Linking performance to objective indicators is best practice but is sometimes difficult to do. It may take DHBs some time to produce information in a suitable format for use. The data required by each professional group is likely to be different.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This is an opportunity to highlight weaknesses and direct vocationally registered doctors to use CME to improve performance and not to develop a sub-specialty knowledge where this is not required. Consultants are often very busy and engaged, the format needs to be easy to use and administratively simple.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Some do it well, others not quite so well. The principal that this sits with the colleges in our opinion is sound.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Whilst good practice, this is potentially costly unless it can be accomplished remotely. The principal is supported especially taking into account the aging workforce.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Recommend not putting too many limitations on what may be required in advance.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Regular vision tests are already in place. Evidence of a GP removes the risk of a doctor self-prescribing or treating family members.

Acknowledging the aging medical workforce it would be prudent to set an expectation that doctors who continue to work after age 65 (definitive after age 70), have an objective assessment of their physical and mental competence to manage the rigors that their position and responsibility places on them. This could be the employer's responsibility to do, and for those in independent practice could be required by MCNZ.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Support the concept of continuous quality improvement. One way to introduce new techniques and knowledge is through a good training programme. All doctors should be encouraged to be involved in training.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Support this approach
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Most SMOs employed by DHBs are getting 3/10 non-clinical time. 1/10 of this which is dedicated to personal development amounts to 168 hours per year excluding leave. The new PDP and RPR process should be able to be accommodated within this time, although needs to be simple to use and not administratively complex.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes, although this depends on what is required.

Southern Cross Hospitals

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17 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Dear Karen

Strengthening recertification for vocationally registered doctors

We welcomed the opportunity to respond to the Medical Council of New Zealand (MCNZ) consultation process using the Consultation Feedback Form.

MCNZ's proposal to strengthen recertification for vocationally registered doctors is supported by us, however given the importance of the topic we strongly believe more options than the one currently proposed by MCNZ need to be canvassed. The Consultation Feedback Form focuses mainly on the role of medical colleges and we have concerns that the complexities that arise as part of, or as a result of, a recertification process need fuller and wider debate especially handling situations that could give rise to disruption and or public harm.

As the MCNZ is aware Southern Cross Hospitals Limited operates New Zealand's largest network of private surgical hospitals with approximately 1000 vocationally registered doctors licenced to access our hospitals to admit and treat patients.

Enclosed is a range of individuals' comments.

We would welcome a conversation on areas for strengthening recertification for vocationally registered doctors. The public (and hospitals) need a more robust process that will work for us and doctors.

Yours sincerely

Terry Moore
Chief Executive Officer
Southern Cross Hospitals

Enclosure: Consultation Feedback Form: Strengthening recertification for vocationally registered doctors

Southern Cross Hospitals Limited
Level 10, AMP Centre, 29 Customs Street West, Auckland 1010. PO Box 5341, Wellesley Street, Auckland 1141
Phone 09 925 5300 Fax 09 925 5301 www.southerncrosshospitals.co.nz

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

Following is a range of individuals' comments.

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

The words are good and the proposal makes sense. The Colleges should assist but most are driven from Sydney and Melbourne. The NZ Committees seems to have little influence. There is the opportunity for confusion if there is not coordination between the Medical Council, the Colleges and the DHBs/facilities providers.

The system works well for NZ Orthopaedic Association with the practice visit program including patient and colleague/nursing feedback. It is fairly comprehensive process so only a certain number of surgeons are visited each year.

We recommend that sources of feedback could include:

- **Patients**
- **Consumers associated with patients**
- **Colleagues – other doctors – anaesthetists need to step up and speak-up.**
- **No point in asking favourite/tame nurses to give feedback -fill out a form and give back to doctor – is a flawed process**
- **Clinical leaders and**
- **Management**
- **External including HDC, ACC treatment injury data sources, Coronial etc**

Colleges ideally should have to assist doctors. The power of a profession is from their craft group. Model RACS leadership in good practice here. But not all colleges are equal: resourcing (money to fund, people to administer, talent to perform complex activities such as re recertification technicalities and communication), mandate membership. Membership is not compulsory and there is no legal mandate so what happens when there are concerns about apparently not meeting standards.

Has the MCNZ consulted with all colleges to determine if colleges are capable of

having to assist doctors?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I am not sure of the assumption that established practitioners can continually "develop ". The characteristic that is needed for review and reflection of our performance clinically is personal insight, what we do well or not well, and the capacity to make appropriate changes. I think this means the selection of medical students and a trainee later is crucial. The format of using template key questions for referencing for example is good.

A somewhat difficult task to supervise in terms of meeting requirements. Certainly easier to make a standard set of requirements.

Self PDP appropriate but this also needs to be signed-off as meeting needs not just a doctor's subjective need. And what happens if the doctor is an outlier or 'bad doctor' as described by Ron Paterson? Self-review is probably what most 'good doctors' do but recertification is more about protecting the public so wouldn't a consumer/employer/or facility provider want to know the regulator or another independent body was monitoring and validating review and performance?

This is a model that is in use with other healthcare professionals including the largest group – registered nurses. Interestingly though this is coordinated by the Nursing Council.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice , including *skills and behaviour* and those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Standards including Consumer's Rights,* the Heath Quality Safety Commission, Health and Safety at Work etc

Question 3:
What is your view of medical colleges defining knowledge skills and behaviour requirements?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

From our National Clinical Medical Committee (NCMC) perspective, we just need to check that the proposed scope of practice and changes in scope are soundly based in knowledge and experience. Of course the Colleges define knowledge for trainees.

If the speciality college won't or can't define knowledge and skills and attitudes (behaviour) requirements then who can/will? Colleges will have to step up more. Performance and outcome data needs to include surgical safety checklist and briefings/debriefing, safe Health and Safety workplaces etc. Colleges will share common generic requirements and additional speciality requirements.

Note the highlighted (yellow) additions to the proposal above.

Probably the best way to do it.

This falls into two areas really; competence requirements and maintenance requirements (currency). I see these as general for all doctors (behavioural, communication, teamwork, general health, health risks, neurological (including reaction times) and cognitive. And then those general and/or specific competencies related to their speciality and all within the context of their particular practice.

Is this something that the Council of Medical Colleges, as the national body, could assist with by defining the general competencies? In consultation with colleges? And then the individual medical colleges the vocational specific requirements? This could also ensure consistency.

An example we are aware of is ANZCA's 3 yearly maintenance requirements of their member that include resuscitation and anaphylaxis management for example.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Practice reviews have been available from the RANZCOG for several years and seem to be useful. A lot of time is required and suitable people as assessors. The Review must be collegial and constructive and not punitive.

Why say 'option'? Shouldn't it be part of being a member of the college? Must be happening not simply optional. But membership of a college is not mandatory either.

Is this is placing a lot of responsibility on colleges that are very small and would they be able to perform in a timely manner especially if college members are providing their services on a voluntary basis? Has consideration been given to conflict of interest situations?

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I have been involved in a few cases and could not attest to support for the individuals from the College nor the hospitals' management. The first responsibility of organisations is to the patients. For practitioners, surely they are sufficiently grownup to identify what are their needs? Ideally, hospital managers will be sufficiently familiar with their staff to monitor performance. It seems to work in all but a few cases.

Agree to the Medical Colleges stepping up to provide additional support - hospitals aren't resourced to do this. Strikes me that the Medical Protection Society (MPS) do most of this but not sure that is their role nor whose interests they advocate for.

Individual professional needs should include (eg: Laser safety, surgical plume, safe surgery processes etc) resuscitation and anaphylaxis management, bullying and disruptive behaviour including; crucial conversations raising and responding to safety concerns.

Regarding those that refuse or are antagonistic about carrying out basic safety checks and practices: will the College sanction below par doctors as well; and how safe will it be for colleagues – see the Commerce Commission information on the risks for healthcare professionals.

Where doctors are employed this is easier but what happens with sole practitioners in terms of oversight, support, leadership, monitoring and mentoring?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors' age? If so, what activities and what age should apply?

The Medical Council still bears the burden of a disciplinary organisation and I doubt that there are the resources to provide in depth monitoring for all. People's

performance may change with age but this is an individual progression. Traditionally, at any age, those of us who are not performing well get a tap on the shoulder from concerned colleagues. I can think that of examples where this has been done successfully.

Closer supervision over 65 and certainly over 70,

Looking at other bodies – bus drivers, airline pilots, taxi drivers...
Should age 55 and or 60 be a starting point and 5 yearly unless there are any deficits or events that trigger a repeat functional assessment?

Suggest yes absolutely the MCNZ must mandate but age may not be a perfect gauge as underlying issues e.g head injury, neurological disorders etc can make doctors unsafe to undertake hand eye coordination tasks, make quick clinical decisions for example. And there are others who are young with significant behaviour problems that make them unfit to practice as part of a team. Then there are situations such as post-surgery or major health problems where diminished function happens initially anyway.

Yes ageing does generally include some diminished functionality but testing must include hearing, eye sight, neurological functionality, reaction times, general health and medical risks etc and be staged at 5 yearly intervals from 55 onwards and more frequently depending on rate of any declines and or onset of health problems.

Career pathways in administration, leadership, surgical assistant roles, coaching mentoring. So that might be another piece of work.

Another approach could be make a 'stop work' age compulsory at a stated age unless the doctor has 'passed' the medical/functional assessment to carry on with particular levels of practice, like a driver's license. Doing assessments would surely be the responsibly of the regulator or specialised agency. A college could be part of an assessment process but not responsible for it.

Agree age is not a clear determinant of competence and assessment for competence should be the more comprehensive approach we have suggested above.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality

improvement. What feedback do you have on the requirements for continuous quality improvement?

Yes, the Colleges collect the points that doctors accumulate. The relationship between that and competence is weak and the notion of continuous quality improvement not always appropriate in some areas where *maintaining* a certain level of practice is what is required.

Specialist room's receptionists can be helpful if they get complaints as patients' pay and leave; otherwise the unhappy patients go elsewhere. Best that doctors' each find their niche in which they can safely practise. Scrutiny is needed for those people who pick up an idea, such as surgical mesh, see it at a conference or on-line and succumb to pressure from distributors.

Currently hospitals collect data from surgeons regarding complications and often have their own wound surveillance etc and this information could be utilised to avoid doubling up on the same data collection.

The Plan-Do-Study-Act cycle must be embedded and Colleges and others could all access a similar/same IT application to run a proper CQI programme. Just be sensible and have one consistent framework/model.

Colleges would need to provide the technical speciality input. CQI process though includes managing issues so which body would do that – MCNZ or another Agency.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Generally, I think that standards need to be realistic, practicable and useful. I am not sure of the Council's purpose in this consultation, there can never be all doctors above average in performance, it should be possible to minimise substandard care and harm to patients and I see that as a professional duty in the workplace. Getting complaints can change practice for the better.

I think any form of quiz to assess knowledge would be difficult with the increasing specialisation within each discipline. For example in orthopaedics I do 80% should but not elbow, wrist or hand. I also do hip and knee replacement surgery. Just how to tailor an exam to assess my knowledge would be difficult.

Good idea but need to make sure all stakeholders get some involvement. Also need to be clear on how 'problems' will be addressed – how to address bad doctors (R Paterson), current system is very weak at this so patients and colleagues and providers are exposed to risks.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

I think the practice program works well but is labour intensive with 2 surgeons vising one practitioner for 2 days.

Need to consider also those doctors practising in isolation, there are a number with no DHB or other group connection.

The recertification assessment results need to be accessible to stakeholders as well to strengthen consumers being able to make an informed choice of doctor.

Set up a repository of publicly accessible information which consumers/employers/ facility providers can access.

The differing capacity of colleges to resource this and the significant cost. It can't simply be mandated, that approach won't work.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Probably.

This seems a long way off. Is there a successful model overseas than can be tried out here? Does MCNZ have the support of all medical colleges for this approach?

Also to implement this requires considerable expertise and resource from colleges and some are very small – for them this would be impractical if not impossible. Hence the suggestion in point 3 above that for consistency and practicality perhaps the Council if Medical Colleges could set the general non-speciality requirements as these are applicable to all doctors.

NEW ZEALAND PRIVATE SURGICAL HOSPITALS ASSOCIATION INC

9 February 2017

email: recertificationconsultation@mcnz.org.nz

NZPSHA Response to MCNZ Consultation on Recertification

The New Zealand Private Surgical Hospitals Association represents:

- 26 Member Organisations
- 39 Surgical Facilities
- 1821 Surgical beds (including ICU, recovery, day-stay chairs and resourced beds)
- 3122 FTE in Staff (combined payroll exceeding $120 million)

NZPSHA members provide procedures for approximately 164,000 patients every year, representing approximately 50% of all elective surgery performed in New Zealand. Principal funders include private insurers, ACC, District Health Boards and paying patients. The large majority of member hospitals provide overnight care.

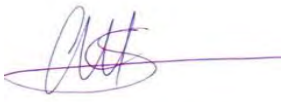
General Comments

The NZPSHA is supportive of the concept to strengthen recertification for vocationally registered doctors. NZPSHA members support vocationally registered doctors by providing a facility to conduct clinical work in and by providing support systems to ensure that a high quality of care is maintained (e.g. M&M reporting, adverse event reviews etc.).

The NZPSHA would strongly recommend that an explicit focus on non-technical competencies is also promoted in the new approach. This would include a focus on the development of competencies in areas such as communication, teamwork, conflict resolution etc. Given the recent focus on reducing discrimination, harassment and bullying within the profession, using the recertification process to promote development and reflection in these areas would be important.

NZPSHA thanks the Medical Council of New Zealand for the opportunity to participate in this consultation

Yours sincerely



Dr Lloyd McCann
On behalf of the NZPSHA Executive

c/- Executive Director, New Zealand Private Surgical Hospitals Association, PO Box 25448, Featherston Street, Wellington 6011
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New Zealand Rheumatology Association

9 February 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
WELLINGTON 6143

Dear Karen

Submission on Behalf of NZ Rheumatology Association

Name: Dr Daniel Ching
Position: President
Organisation: New Zealand Rheumatology Association
Do you agree to your submission, or parts of your submission being published: Yes

The documents on consultation on strengthening certificate for vocationally registered doctors were discussed at the Executive Teleconference for New Zealand Rheumatology Association. We note the proposals for recertification will involve the Medical Colleges requiring vocationally registered doctors to meet new accreditation standards. This will involve a lot of extra work in collecting performance and outcome data. The Royal Australasian College of Physicians will be asking specialist societies to do this for them. New Zealand Rheumatology Association is a small specialist society representing approximately 50 practising Rheumatologists. The shortage of Rheumatologists in New Zealand has been well documented by the Association of Salaried and Medical Specialists. The impact of this extra work will reduce our ability to provide Rheumatology services in New Zealand and thus, the care of Rheumatology patients.

Kind regards
Yours sincerely

D W T CHING
NZRA PRESIDENT

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Charities Commission Registration: CC30207 GST No: 60-629-846

Website http://www.rheumatology.org.nz

10 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
Email: recertificationconsultation@mcnz.org.nz

Dear Karen

Consultation on strengthening recertification for vocationally registered doctors
The New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to make a submission on the above Medical Council of New Zealand (MCNZ) consultation. We support the MCNZ's Vision and Principles for Recertification.

About the New Zealand Society of Anaesthetists
The NZSA is a professional medical education society which represents over 500 medical anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, and trainee anaesthetists. We facilitate and promote education and research into anaesthesia and advocate on behalf of our members to advance their professional interests and the safety of their patients. As an advocacy organisation we develop submissions on government policy and legislation, work collaboratively with key stakeholders, and foster networks of anaesthetists nationwide. The NZSA, established in 1948, also has strong global connections, and is a member Society of the World Federation of Societies of Anaesthesiologists (WFSA).

Overview
The NZSA strongly supports developing a practical and effective pathway to strengthen CPD so that doctors remain competent and up to date throughout their working lives to deliver optimal care for their patients.

Standards and knowledge requirements for anaesthetists
The Australian and New Zealand College of Anaesthetists (ANZCA) sets the standards for training anaesthetists and determines the profession's knowledge requirements. The ANZCA CPD programme is arguably one of the most comprehensive among medical colleges and covers most aspects of what is considered valid to assess. The CPD portfolio, which the college mandates, is in line with this new proposal, including a personalised learning plan. Annual, in-house peer reviews of practice is also an option under the college's CPD and useful for anaesthetists, as many tend to practise in a degree of isolation. The ANZCA portfolio encourages case review meetings.

The proposed MCNZ changes could potentially be a technical and financial burden on some colleges, and we recognise the variation in CPD offered by some colleges. ANZCA may be able to assist other colleges to implement changes by licencing its successful model to other colleges.

It is very important for the Council to be clear on the difference between standards and guidelines as set out by the colleges.

Performance data
The MCNZ proposal states that each doctor will need to use a range of sources to identify their personal development needs, including outcome data and external peer review.

Performance data tends to be ineffective for anaesthetics and the standard has to be poor before bad outcomes are consistently encountered. We support the use of outcome data in principle, where it is applicable to assist with exposing competency lapses and to encourage further learning. The MCNZ proposal appears to be a justification for enforcing regular audits, which we don't believe will make a difference to identifying poorly performing anaesthetists. We need to avoid placing a large burden on the profession and require a mechanism which provides meaningful information, rather than a box ticking exercise.

IT support and data collection to identify individual practitioner outcomes is rarely available. Individual practitioner audits of their own patients, which compare group results or benchmarks, if available, are useful but difficult, time-consuming and hampered by recent changes to ethics committee approvals which lead to significant delays.

Additional support for doctors based on individual professional development needs
Coronial investigations into adverse outcomes from underperforming doctors might be complicated by the fact that most colleges are based in Australia. Therefore, it may be preferable for this to be undertaken at a departmental level, with compliance checked by the college when accrediting departments.

If there are extensive and expensive CME requirements, such as peer review by those from a practice elsewhere, then the Council will need to provide financial support to all involved to cover costs associated with travel and time away from normal work.

ANZCA has a Welfare Special Interest Group, but this may have to be strengthened to comply if the College were made responsible for providing support.

Regular practice review
We support regular practice reviews remaining optional and would not be in favour of them becoming mandatory. Mandatory reviews would be laborious and expensive, and ANZCA has opposed mandatory reviews in previous submissions. Compulsory full peer reviews every three years would reduce anaesthesia workforce capacity. There are about 900 anaesthetists in New Zealand, so this would potentially be a huge loss of productivity each year which the system cannot afford.

We wish to comment on point 4b which refers to "…a review undertaken by peers external to the doctor's usual practice setting." It is not clear whether this is external to the physical setting of where you work. While this would be fine in a large hospital with myriad departments it would be difficult elsewhere and make the process more arduous, unaffordable and impractical.

MCNZ must provide clarity on what is meant by 'peer review.'

New Zealand
SOCIETY OF
Anaesthetists

Mandating activities for ageing doctors
Regular CPD should be sufficient to maintain standards for ageing doctors. Competency should be assessed as for all groups and not be ageist. Stipulating an age that this applies to, and mandating additional activities and specific testing, will overburden a large population, and still miss underperforming younger Anaesthetists. The additional requirements would be onerous and our health system would risk losing the valuable insights and experience of older doctors, which enhance patient outcomes.

Practitioners should however recognise that planning for retirement is an important part of career planning and there should be awareness of changing capabilities as a doctor ages, with support available if required. We support ANZCA recommendations concerning ageing specialists, and would advise that all medical colleges should have recommendations in place for ageing practitioners to support them in their practice, and to uphold patient safety.

Summary and closing statements
We are interested in the evidence base behind the effectiveness of the MCNZ's proposals and would urge that international literature is evaluated, if this has not already been undertaken, to see what has worked in other countries.

Achieving objective measures of competence is well underway with new assessment tools in development, including simulation. Further research is needed to look at effective and feasible tools of assessment.

We believe the three-year timeframe recommended by MCNZ for recertification changes to be implemented is reasonable.

Yours sincerely

Dr David Kibblewhite
President

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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Group ✓ [redacted] **Do you agree to your submission, or parts of your submission being published**: No ✓ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ✓
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The principle of using doctors' performance and outcome data is sound. However the practicalities of doing so within a recertification framework are challenging. 1. If left to the individual the selection of what data to use might not address areas of difficulty or practice gaps but might be chosen to display performance in areas of clinical familiarity and comfort. If imposed from outside (e.g. formulated by a college) the data parameters may not be universally applicable. 2. Multisource feedback is increasingly popular but problematic. Selection of feedback sources, maintaining anonymity, formulating the feedback obtained and delivering the feedback in the right

context are all challenging. Multisource feedback done well requires expertise, time and **resources** which don't exist within financially challenged DHBs. Who will pay for the multi-source feedback to be done well?

3. Providing consistent "in-house" or "within team" formal peer review is challenging enough in busy clinical services under the pressures of health targets and restricted resources. Mandating peer review "*by peers external to the doctor's usual practice setting"* will be extremely challenging and likely impossible in many settings.
4. *"The minimum each year is a structured conversation with a designated senior colleague".* It would be very useful to mandate a feedback and development review for all employed SMOs but their clinical director, although a senior colleague, is unlikely to be considered 'external' to the doctors' practice setting. We are struggling to ensure all our SMOs have feedback and development reviews and a mandate from the Council, similar to the requirements in the UK, would be helpful. Those not employed could then arrange a"structured conversation".
5. The availability of performance and outcome data will vary dramatically between college craft groups, work-sites, services and teams. What does a doctor do in the absence of validated, relevant outcome data?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This part of the proposal has merit as it encourages "good intentions" to be documented in writing which can then be checked and revisited. However to be effective it relies on the insight and accurate self-awareness of the individual doctor to formulate a PDP which addresses areas of weakness or with room for improvement rather than reinforcing areas of current clinical competence and comfort. In addition extra time will be required to formulate a PDP and at present many senior doctors struggle to find any significant non-clinical time to address this kind of activity.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 3:
What is your view of medical colleges defining knowledge requirements?

The colleges are well placed to define knowledge requirements although there is a risk that the colleges will produce expansive documents which become as ambitious and unwieldy as some of the advanced training curricula have become.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Whilst RPRs can be a very effective tool and a learning opportunity in its own right for reviewers and the doctor being reviewed they are challenging to organise and conduct. There are considerable costs involved in conducting an RPR and it is not clear in the proposal where those costs will lie?
There is also limited availability of assessors. Even for Medical Council VPAs and competency reviews it can be difficult to find reviewers with the time to undertake these. These reviewers are the same people the colleges would want to use. The Colleges already put huge demands on their fellows.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Medical colleges are too removed from individual work places to provide the kind of individual support described here. This is the domain and responsibility of the employer's clinical leadership structure and this support will vary dramatically between workplaces. Direct involvement of the Colleges could well be counterproductive.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Medical colleges should take a lead in the discussion on this part of the proposal. However defining an age where certain activities are mandated will be fraught with problems. The factors (cognitive, physical and technical) affecting an individual's performance as they age vary significantly between medical craft groups. It is possible this could also be discriminatory. There are many non-age related problems which can cause doctors to underperform at any stage of their career.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

It is unclear from the proposal as to whether the colleges would be in some way responsible for demonstrating that continuous quality improvement has been achieved or whether they are required to ensure that quality improvement ***activities*** with a proven track record of achieving improved outcomes have taken place?
The data colleges are able to collect is summary data – they would not have the ability to analyse individual improvement activities. They may end up doing what RACMA has – in mandating that points are achieved by attending only college provided CME. This actually discourages SMOs from extending and improving – only assists them to tick a box.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

This is logical and consistent.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There are considerable barriers and challenges some of which have been pointed out in responses to

previous questions. There seems to be an assumption that medical workplaces already have mechanisms and processes for regular review of activity and performance underpinned by accurate and relevant outcome data and the proposals look to build further sophistication and detail into the system. Unfortunately the reality is that those processes are very patchy at best and that accurate data collection and compilation is not always available in a useful format to clinicians. The proposed recertification model runs the risk of stressing a faltering system and failing to deliver meaningful results.

On the other hand many on-going clinical review processes occur during the course of daily multi-disciplinary care e.g. tumour board meetings, joint ward rounds, shared in-patient cover arrangements, MDT meetings etc.. where performance of peers is constantly on view and constantly being reviewed. Knowledge of those kinds of clinical activities might provide all the information a re-certification process requires without introducing new measures and processes.

Ensuring that all employed doctors have regular performance review and are appropriately credentialed would be a better start – with parallel processes in place for those who are self-employed.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

This is overly ambitious.

Appendix 1

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this? Agree with proposal. Assistance from colleges would be helpful and reasonable.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year? Agree with proposal.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?
Agree that this is a reasonable expectation.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?
Agree that it should be an option developed by all colleges, although there will be resource implications that will be borne by employers, which should be acknowledged.

[3] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs? This support is more likely to be available & provided by employers than by colleges.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply? It would be helpful to mandate reviews from a specific age - suggest 70yo. This might be the group to mandate RPR for - eg. every 2 years.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement? Evaluation of the recertification programme is an excellent idea but really this evaluation should be developed + led by the MCNZ so there is one evaluation methodology for all. Developing that methodology will be itself challenging! Ensuring that it is a cost-effective step would be useful.

General Questions:

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?
No

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?
Resource implications - for individuals, employers & Colleges - should be considered and addressed.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?
Yes but I suggest that first you should
(a) consider the resource implications + cost those
(b) develop the evaluation methodology
- and then you should be prepared to reconsider if the evaluation suggests that the recertification process is not proving cost-effective & adding value to the health system.

NZSPS response to MCNZ Recertification Proposal:

Intro: The NZ Society of Paediatric Surgeons is a small professional society that represents the 19 Paediatric Surgeons in current practice in NZ's 4 main centres (Auckland, Hamilton, Wellington and Christchurch). Our other professional organisation is the Australian and New Zealand Association of Paediatric Surgeons (ANZAPS), but in general it is the responsibility of NZSPS to respond to New Zealand issues for our craft group.

The NZSPS is grateful for the opportunity to comment on the process around recertification in medical practice. Its views are broadly aligned to those of the RACS NZ Board, but it would like to highlight some specific issues that relate specifically to our specialty.

Issues:

1. Bi-national consistency. The MCNZ framework and focus is rightly on the protection of the NZ public, but our training program is binational and the scope of practice of paediatric surgery is derived from binational decisions. In a small specialty such as ours, there are advantages if there is broad consistency across Australia and NZ. We would support a framework that is consistent with the AMC recertification processes that would allow ANZAPS to administer the programme to fellows in both countries.
2.
3. Resourcing in a small specialty. The NZSPS is too small and not sufficiently resourced to monitor a separate CME/Recertification programme Surgeons' performance and outcome data: The collection and availability of outcome data is an important plank in ensuring ongoing high quality care. There are several issues around this that affect its application to paediatric surgery. One is that the factors that influence clinical outcomes are complex. In our specialty outcomes for many conditions relate as much to the quality of paediatric anaesthesia and per-operative care as they do to surgical aspects. Outcomes reflect the contribution made by the many individuals and systems involved in the patient journey. The individual contribution of the surgeon is very important and the surgeon's role as a leader in the process is crucial. However, as a measure of the individual's targeted personal/professional ability, this may be an unreliable tool.

4. Limitations of outcome data as a measure of quality in paediatric surgery for rare and complex conditions: The NZSPS has concerns about the risks around the collection and availability of outcome data in our specialty. There are many (important and complex) conditions we treat that occur infrequently and are quite variable in terms of their presentation, severity, co-morbidity clinical course and determinants of outcome. There is a paucity of reliable international outcome data for these and complex conditions. Furthermore, some conditions are so unusual that it would be meaningless to report on them publically, as it would risk breaching confidentiality. Also, it is recognised that in rare conditions with variable outcome, data need to be treated carefully to avoid unjustified reactions based on the normal

variability that reflects small numbers[1]. And no single institution in New Zealand would be able to collect sufficient numbers for any valid analysis of outcome to be performed.

5. Benchmarking: we would support collection of data for certain selected conditions or outcomes that could be demonstrated to be useful indicators of outcome. Usually, this would be as part of an international project or research study, or an Australasian clinical indicator data set
6. Misinterpretation of data: We also call attention to a tension between honest self-reflective data analysis that seeks to identify areas for potential improvement even in the context of a high standard of care and data that might find its way into the public domain and could ultimately be utilised for purposes other than those for which it was originally intended. Surgeons need to feel safe when undertaking critical review of management decisions and complications.

7. Methodology around assessment of clinical performance: NZSPS recognises that Multi-source feedback (MSF) is generally considered the best validated tool for assessing clinical performance. Our members' experience with formal professional practice visits (in the context of MCNZ Vocational Assessments) as a component of assessing performance involves significant cost and disruption, but has significant limitations. Our group is not aware of any objective evidence that it is an effective tool when used as a routine. We would not support mandated site visits as part of Regular Practice Reviews and see it as being an ineffective and expensive undertaking, when better information could be gained by MSF. We do agree that regular performance appraisals should be performed, and would urge that at present, MSF in conjunction with a rigorous clinical audit process would appear to be the best tool for assessing clinical performance.

8. Identification of the poorly performing surgeon: We would contend that clinical audit and MSF would be the best method to identify the currently poorly performing practitioner.

If the aim is to proactively assist the potentially poorly performing practitioner and more importantly, to engage the isolated practitioner in a collegial support system, then a form of surgical coaching[2] would also need to be provided.

9. Individual Professional Development Plan (PDP): The NZSPS supports this, with caveats. Doctors do not always recognise their own learning deficits and needs[vii] " Therefore doctors would be best served by having a collegial/mentoring relationship appropriate to their needs and the needs of their

[1] Nokuthaba Sibanda, James D. Lewsey, Jan H.P. van der Meulen, Mark D. Stringer, Continuous monitoring tools for pediatric surgical outcomes: an example using biliary atresia, Journal of Pediatric Surgery, Volume 42, Issue 11, November 2007, Pages 1919-1925, ISSN 0022-3468, http://dx.doi.org/10.1016/j.jpedsurg.2007.07.023. (http://www.sciencedirect.com/science/article/pii/S0022346807005064)

[2] http://www.surgery.wisc.edu/research/wisconsin-surgical-coaching-program/

service i.e. in clinical context. There acknowledge that there can be a tension between the doctor's own desires for professional development in a direction of their choice, and their employer's requirements for service delivery. Weaknesses in the doctor's skill mix that might not be acknowledged, and maintenance of general skills that are important for emergency service provision are crucial. Within our specialty (and others) there is a tension between the development of sub-specialty expertise to improve elective outcomes and the maintenance of general emergency and trauma skills for the provision of safe out of hours' emergency care provision., Any roster must ensure good care provision and protect the quality of work life integration for those on the roster. We support a framework that emphasises professional development in all areas of service provision. A sub-specialist in NZ may need to develop a mentoring/coach relationship with a practitioner with a similar practice in Australia.

10 Assessment of knowledge as part of recertification: This is already defined by our college in terms of what constitutes the knowledge required for a newly graduated Fellow in our specialty. Scope of practice varies over time, often according to service requirements. Lack of knowledge ir rarely a significant factor in issues that arise around patient management in our specialty. Most problems can be traced back to issues that occur in the non-technical competencies, such as communication, teamwork, etc. Even when mistakes in clinical judgement are made it is usually not the absence of knowledge but rather, around the failure to apply it in the correct context. Absolute definitions of correct answers to complex clinical issues would be beyond the scope of any recertification process we could develop.

Conclusion:

1. assessment of clinical performance would be more useful than assessment of basic knowledge, as it encompasses the clinical application of that knowledge as well as the non-technical skills
2. MSF is currently the best tool for doing that, as it incorporates peer review, and comes from a variety of sources. Combined, it covers all competencies
3. Regular routine site visits are resource-expensive (time and cost) and perhaps only have a role for further investigation of the surgeon where there are concerns about performance

Submission On behalf of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons - New Zealand (ANZAOMS - NZ)

Preamble

ANZAOMS (NZ) is grateful for the opportunity to submit to the Medical Council a reply to the questions below. The views are those of the New Zealand members of this Australasian group.

Proposal:

Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

ANZAOMS (NZ) Response:

Concern has been expressed regarding what exactly these performance and outcome data sets are, and how this data is used apart from guiding

professional development needs, which is laudable. ANZAOMS (NZ) membership would oppose a move towards publicly available league tables on individuals, and would trust that all data collected on individuals remains strictly confidential. Many colleges, including the Royal

Australasian College of Dental Surgeon, who, through the Board of Studies, administers training and continuing education for Oral and Maxillofacial Surgeons, have both Australian and New Zealand membership, with most members being Australian. It is not clear whether these Australian dominated colleges would see any value funding recertification activities unless this became an Australian and New Zealand issue.

Proposal:

Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

ANZAOMS (NZ) Response:

ANZAOMS (NZ) feels that individualised PDP is likely to contribute to meaningful career development and agrees that is should form a central part of recertification.

Proposal:

Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence[3], cultural competence, and the Code of Health and Disability Services Consumer's Rights.

Question 3:
What is your view of medical colleges defining knowledge requirements?

ANZAOMS (NZ) Response:

ANZAOMS (NZ) feels that this is appropriate, as the RACDS and its Board of Studies have intimate knowledge of the training requirements and scope of practice of the specialty

Proposal:

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

ANZAOMS Response:

ANZAOMS (NZ) feels that this should be left as a discretionary activity. However, RPR has the potential to act as a powerful feedback tool and for those opting to undergo RPR, and ANZAOMS (NZ) wonders whether colleges could incentivise surgeons to opt for this pathway. For example, RPR could count as a greater percentage of required CPD

Question 4:

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

ANZAOMS (NZ) Response:

ANZAOMS (NZ) acknowledges the success that the InPractice programme of recertification for non vocationally registered medical practitioners has had, and that a key component of this is RPR. RPR however is time consuming and expensive. The Medical Council's Vision and Principles for Recertification state that this process should be supported by employers. Members are concerned who will pay for recertification and how well tolerated RPR will be in public and private practices if at any one time a large proportion of the vocationally and non vocationally registered medical work force may be undergoing PRR at any one time.

Proposal:

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

ANZAOMS (NZ) Response:

ANZAOMS (NZ) supports this, but is mindful that this process is likely to be expensive and time consuming

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

ANZAOMS (NZ) Response:

Again, questions of payment and impact on existing services need to be considered

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Proposal:

Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

ANZAOMS (NZ) Response:

ANZAOMS (NZ) supports continuous quality improvement, along with continuous career development. ANZOMS (NZ) does not believe Council or Colleges should mandate on age alone, but believes that a robust recertification programme will identify strengths and weaknesses across all age groups.

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

ANZAOMS (NZ) Response:

ANZOMS (NZ) feels that continuous quality improvement is a important aspect ensuring public safety, the data collected must remain confidential, and act in an auditable 360 degree process of feedback (ie recommendations are implemented and are shown to be effective). The vehicle for collection and analysis should be robust.

General Questions:

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

ANZAOMS (NZ) Response:

ANZOMS(NZ) feels that while this process of recertification is commendable, that timeframes for institution should reflect the large body of work that this is likely to be, with trans-Tasman implications, and opportunities for collaboration. At this stage, there is only one provider in New Zealand with experience in recertification, and ANZAOMS(NZ) would like to see viable competition, which could be college based. It agrees

that this process should be led and administered by each specialty, and that RPR when used, should be by someone within the specialty.

The impact of the entire vocationally and non vocationally registered medical work force being constantly at some part of the recertification cycle should be considered and ANZAOMS (NZ) wonders if this work hasyet been done? Discussion with District Health Boards and the implications this may have on the collective employment contract (MECA) should also be considered.

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

ANZAOMS (NZ) Response:

ANZAOMS (NZ) members belong to an Australasian college (RACDS). It is not clear whether the Australian membership would support financially or administratively this potentially expensive and complex work. It is understood that the Australian Medical Council may be considering a similar prohramme, offering scope for collaboration

Additionally, ANZAOMS (NZ) members are vocationally registered not only with MCNZ, but also with the Dental Council of New Zealand (DCNZ). DCNZ is currently consulting with dentally registered practitioners on their own recertification programme. It would be desirable that MCNZ and DCNZ recognised each others recertification process for Oral and Maxillofacial Surgeons, in order to avoid duplication.

ANZAOMS supports a 3 year cycle of recertification and supports the concept of annual audit. Assessment of components of this however, should lie within the 3 yearly cycle rather than annually.

Finally, ANZAOMS (NZ), wonders what role Council will have in this process, aside from enforcement. If deficiencies in performance are identified and are institutional, rather than individual (and thus lying outside of College influence), does Council have the mechanism to effect change at that level?

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

ANZAOMS (NZ) Response:

ANZAOMS (NZ) feels that this time frame may be limited, give the trans-Tasman impact of this proposal for many colleges, and the infrastructural work need to set up a robust recertification programme.

Antonia O'leary

From: Allan Moffitt <AllanM@procare.co.nz>
Sent: Thursday, 23 March 2017 8:31 a.m.
To: Strategic Consultation
Subject: Feedback re consultation on recertification

Apologies,
As I realise that feedback has closed. I'm not sure how I missed the deadline as intended to respond on reading the Council statement in February but put the wrong reminder date in my diary! However I wanted to formally send word regarding our concerns for the older medical workforce and the need to support these practitioners to continue in practice for longer so that the NZ Public may continue to receive access to especially primary healthcare.

Given that 41 % of the GP workforce has indicated a desire to retire by 2025 and the lack of supply to replace this number ProCare has concerns that we will need to retain GPs working in practice for longer. Our members tell us that the biggest driver for them to retire early is the compliance costs and bureaucratic burden placed upon them including MOPS. We request that the council consider this when balancing their requirement to ensure that practitioners remain safe and effective against lack of access to any quality primary healthcare. This is compounded by the fact that 57% of nurses are likely to retire in the next 5-10 years.

We have grave concerns that if we do not nurture these older GPs then NZ health system will suffer as a result to the detriment of the health of New Zealanders.

Regards,
Allan

Dr Allan Moffitt | *Clinical Director*
O.StJ.; B.H.B.; MBChB; Dip Obs; AFACHSM

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Pinnacle
Midlands Health Network

14 March 2017

Pinnacle submission to MCNZ concerning
Recertification of Vocationally Trained Doctors

To whom it may concern,

Pinnacle is a network organisation of 90 practices across 4 District Health Board's in the North Island of New Zealand.

The proposed changes to the MCNZ process around recertification spontaneously arose in several meetings with member GPs and given the passion of the expressed opinions it was decided to collate them and contribute to the MCNZ exploration of this proposed change.

In summary the feeling was that the current system is better than what is proposed.

There was concern about the cost both in time and money and the impact of the changes proposed:

"I am concerned that the new process is going to be expensive and onerous in the form of jumping through hoops (audits, questionnaires and visits) without necessarily supporting me in what I need to do to become a better doctor – all of this stuff sounds like it is actually on TOP of what I need to do to keep up my competence e.g. the actual CME and peer review."

"I run a small rural practice – who is going to pay for all this? Who will do the reviews? I would want it to ne a trusted colleague who knows my sort of practice – I suppose I could retire and become an assessor."

"Good doctors have nothing to fear but will become demoralised doing meaningless recertification exercises repeatedly so the recertification period has to be long maybe 5-8yrs. Less good doctors need help and support to get back on track; on the whole not bad people but often burnout stress depression external pressures are the root cause of problems."

There were parallels seen in the proposal with the system in the United Kingdom. The impact of the change was seen to be so significant that it would drive providers out of practice, as is perceived to have happened there:

"There is now at least a 10-15% vacancy rate in General Practice in the UK and whole towns without GPs (look at Frinton on Sea and Clacton on Sea) and recruitment is falling through the floor."

"There are many reasons for this but a major one is the bureaucratic nightmare of appraisal and revalidation which was introduced post-Dr Shipman to try and increase the regulation and quality of Doctors. It is probably the single strongest driver of Doctors into retirement of any factor in the UK. GPs time their retirement by their revalidation date."

There were questions raised about the evidence base to the process proposed:

"Having a look at available evidence, it would seem there is little to support the use of MSF, or PDPs which they seem so keen on. I am also concerned about measuring performance. Medical is not an objectively measurable outcome. A doctor with poor outcomes in an area of deprivation, may well be better than another doctor in an area with good access to healthcare."

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“Unfortunately, an increase in tick box exercises that stop doctors being doctors, and instead has us sitting to fill something in instead of doing something productive does not advance the profession at all.”

There was a feeling that any revalidation process should be formative and not summative, that as a process revalidation is not a good way to identify nor deal with poorly performing doctors.

“Good doctors are self-motivated to continually develop their skills and stay up to date. We should learn from the UK model which has been aggressively attacking good doctors and failing on the whole to address the not so good. Recertification will result in a demoralised work force without making significant inroads into poorly performing doctor’s behaviour.”

There was some positive opinions expressed about the structured conversation with a senior colleague however it was felt that it was:

“Important to think of how who and why; we would need to pick our "appraisal team" carefully; incentivise them in a meaningful fashion and teach a cohort of doctors to become appraisers going forward. Definitely college led but by can only be done by peers so doctors appraise doctors”

A professional development plan was seen by some as a good tool:

“*PDP when used correctly are a tool to encourage a conversation about how well we work, why we work, what motivates and depresses us, not a tick box useless implement.”*

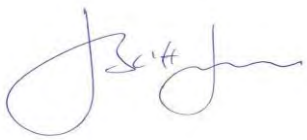
“There was concern about the implications of focusing on “older doctors”:

“Should the MCNZ mandate a candidate’s age? No, different individuals function differently at similar ages, let's not use blunt tool but be thoughtful and considered about how we respect a lifetime of experience (I am not quite 49!)”.

There was an expression of concern that this was the start of a “slippery slope” that would lead to general practice being revalidated and accredited in the same way that practice nurses are and concern that the need to develop a portfolio like response to discuss with an accreditor would be onerous and paper work heavy.

In summary again, the feeling was that the current system is not broken and does not need change.

Yours sincerely,



Dr Jo Scott-Jones
Medical Director
Pinnacle Midlands Health Network

10th March 2017

Submission to Medical Council of New Zealand on changes to re-certification requirements for doctors

The NZ Society of Cosmetic Medicine (NZSCM) would like to submit on the proposed changes to the re-certification requirements for doctors in NZ.
NZSCM functions as a special interest group under the RNZCGP and administers regular clinic visits and assessments of all members of our society. It also acts as the specialist body processing assessments of doctors from outside jurisdictions and delivers a 2 year Training Program for Cosmetic Medicine.

We would like to address the proposed requirements point by point.
Participation in an accredited re-certification program:

i. Practice audits are already part of the RNZCGP MOPS programme. As these audits require the completion of an audit cycle over the course of 3 years we believe that this requirement is already met.

ii. Multi source feedback through questionnaires is a reasonable easy way to collect information. The relevance and follow-on from these, is a much more difficult proposition.
Standard questionnaires need to be relevant to the field of activities the doctor is involved in. As the practice of cosmetic medicine is very different from mainstream general practice, NZSCM would necessarily need to be involved in developing these tools. This will have cost and workload implications for smaller organizations such as our society.

iii. Clinic reviews are already undertaken by all members of our society and we believe that our arrangement is one of the few compulsory re-certification schemes in NZ. Our recertification scheme assesses facilities, documentation as well as the clinical activities of our members.

However, the identification of individual participant's development requirements is a significant undertaking. We are not sure how this could be undertaken without building assessment tools that can be used for the collection of information prior to the triennial re-certification visit.
Again, this will have significant workload implications.

Whilst a structured conversation is clearly the gold standard, this is difficult to achieve outside of a DHB environment. Almost all of our members work in individual clinics with little opportunity of peer to peer contact outside of conferences, peer-review meetings and the triennial visit.
As all practice visitors are necessarily experienced colleagues, it is also likely that some reluctance is encountered in disclosing plans around one's business.

These points have been addressed above. Our major concerns are centered around the workload implications for both the colleges involved as well as the individual doctors.

a. Defining knowledge requirements will involve NZSCM as the main author of these documents within the RNZCGP framework. Without additional staff this task is not able to be completed.

b. this point has largely been addressed above.
RPR in the form of the NZSCM re-certification program has proven to be robust and sustainable. However, administering such a program across NZ with only a small number of experienced volunteer "visitors" is a difficult task and has come at a large cost. discussed above

a. This activity is currently undertaken mostly at the beginning of a cosmetic doctors career to provide guidance and support.

b. discussed above

c. discussed above

This requirement is an obvious part of any recertification program and will not cause any additional hurdles for NZSCM.

Most of these points can be met with relative ease. We would like to request some clarification of point c.: availability of the program for non-members.
Whilst it is fairly straightforward to include these individuals into the actual visitation schedule, it is almost impossible to then fulfill all other requirements put onto the colleges by MCNZ. Non-members are not subject to the same disciplinary processes as members and are therefore unlikely to participate in any college administered programs in a meaningful way.

There simply cannot be a two-tiered approach on college level. If MCNZ allows individual practitioners to remain outside of college (or society) educational and assessment structures, then these individuals remain the responsibility of MCNZ. Colleges are in no position to take responsibility for non-members.

In summary we do not see any major philosophical disagreements arising out of this document. Indeed, the NZSCM has been the first “college” to administer a compulsory 3- yearly re-certification programme for its' members.
However, as outlined above, the creation of such a comprehensive program as expected in the assessed document will require significant funding and manpower. This is a challenge that cannot be met by our society without support from either the MCNZ or the RNZCGP.

Dr Hans Raetz
President
NZ Society of Cosmetic Medicine

Submission to MCNZ and RNZCGP concerning Recertification of Vocationally Trained Doctors

INTRODUCTION

We are a group of generally older rural GPs, some of us locums, who meet regularly as an on-line peer group. We have worked in New Zealand for most of our professional lives but have also experienced reaccreditation/revalidation/recertification processes in other countries including Australia and the UK. We acknowledge the need for maintenance and enhancement of the quality of care we deliver to patients and have all found some aspects of these processes to be rewarding in our continuing professional development (CPD).

However, there have been elements of externally imposed requirements, which have been onerous, unproductive and at times expensive for the clinicians, leading to a sense of oppression and contributing to burnout. This creates the absurdity of the very exercise intending to *demonstrate* high quality practice, having a negative effect on quality *delivered*.

We would like to present our collective experience of CPD in the hope that it will guide the MCNZ in restoring an enthusiastic clinical workforce, dedicated to their own professional development in the context of honest and trusted collegial relationships.

(It should also be said that the presentation of the proposed new recertification came without prior warning that this process was underway and with what seems to have been minimal consultation of the wider membership of the Colleges. Furthermore it arrived as a modest e-mail, which might easily have been missed and with a relatively short time frame allowed for submissions on what appears to be a '*fâites accomplis"*.)

POSITIVE AND PRODUCTIVE EXPERIENCES

The more valuable CPD activities fall into the formative group based on a doctor's self-awareness and reflection.

- Most of us have appreciated the annual **Professional Development Plan** exercise and sharing it with a colleague makes for interesting discussions.

- We have enjoyed the **rewarding experience of a respected colleague spending time with us in practice**, allowing shared reflection and professional development. We suspect it offers something more apposite than ticking off some 'measurable data audit'. In the UK, time with an appraiser also offers supported reflection on critical incidents and patient complaints, which are certainly very valuable exercises.

- **Peer group meetings**, particularly those informed by pooled patient or practice experiences and supported by online resources, have a significant

impact on changing behaviour or ensuring that one's practice is within the range of 'good practice' while recognizing that 'best practice' rarely completely fits individual, real life situations.

"Peer review activities give the opportunity to share all sorts of various events around our practice from clinical developments, clinic cases and management changes to ethical, moral and personal dilemmas.
Peer reviews have been a hugely enjoyable and supportive part of my practice since they started about 20 years ago. I think they contribute in a positive way, which is immeasurable to professional practice, and it would be sad to see them slip away if they are no longer part of the requirements of "CPD to address PDP".

- **Attendance at conferences and CME** events is another area that tends to enliven practice, mainly through the wealth of professional and social interaction, the building of new relationships and the chance to value our part within a rich and varied profession. The specific gains in skills or knowledge from these events, are of course often very valuable, but on many occasions may be few in number and secondary to the collegiality. We recommend the awarding of 'Peer Group' credits in addition to 'CME' points for these events

- **Practice reviews**, based on the collective team and its functioning rather than focusing on individual doctors, have their merits. However they are becoming increasingly onerous, focusing obsessively on systems possibly to the detriment of the *quality of consultations,* which are not the cornerstones but the very *core* of primary care.

- The experience of either having a locum in your practice or being a locum in someone else's practice is another powerful source of collegial review. Many in our rural group are full time peripatetic rural locums and see things which differ to our own practice giving great opportunities for cross-semination of ideas, techniques, clinical understanding and practice management to our mutual benefit. This needs to be acknowledged and the parties perhaps specifically encouraged by the College to make the most of these opportunities.

DOUBTFUL EXPERIENCES

1. **Multi-Source Feedback**: there would seem to be a certain charm about this process as it has potential to either reassure clinicians that all is well or pick out deficiencies which would benefit from change. However they do not tend to live up to expectation. The main drawbacks are:

- Firstly, that a standard 'tick-box' 1 – 10 scale of response is unproductive and has not been shown to change behaviour in GPs (although has done in some respects among junior doctors)

- Secondly, that colleagues tend to be cautious in their responses and it is rare for deficiencies to be identified of which the doctor was not already well aware. Indeed, we tend to be far more aware of our own deficiencies, which others fail to detect.

"I did one as a College trial early in 2016. It was similar to one I did in the late 2000s (360). They give glorified comments and reveal none of my deficiencies. I know my own deficiencies, I think I mostly acknowledge them to myself, and I endeavor to address them in my daily practice. These are not clinical deficiencies they are in my personality and practice habits. They are never revealed in any practice assessment I have ever done. I don't put them in writing in any practice review. I prefer to inwardly acknowledge them and work to manage them as best as possible to ensure they don't encroach on the quality of may practice."

- Thirdly, that providing carefully thought out constructive feedback is challenging and time consuming. If colleagues are to reciprocate, each might be looking at providing perhaps 20 such feedbacks a year. How will we find the people prepared to do it? If done conscientiously, this would be extremely burdensome when resources are needed so badly for clinical care, or there may be a temptation to respond cursorily along a line of least resistance, which would nullify its value.

2. We are concerned that the pursuit of **"good quality outcome and performance data"** will on the one hand fail to measure what is important in a doctor's practice reflecting the *care* of her/his patients and on the other hand impose time consuming and energy sapping demands on doctors which would be better devoted to patient care itself. There is a danger that the pursuit of *measuring quality* can have a detrimental effect on the *actual quality delivered* to patients. Do we then see more mistakes occurring, more disgruntled patients and a new round of 'checks and balances' imposed, so continuing a vicious circle of an increasingly stressed workforce resulting in deteriorating satisfaction and quality for all concerned?

(We note that in the UK, the QOF and their Revalidation programme has put so much pressure on the primary care workforce that there is now a crisis of retention, doctors are taking the earliest possible retirement and the NHS is appealing to those who have gone overseas to return. Can we not learn from their experience?

It seems from the latest missive from the GMC that they are seriously reconsidering these stresses on their medical workforce. If the statement of their Chair, Prof. Terence Stephenson, is going to gain traction, they may be starting the move away from cloying accountability back towards trust in responsibility and professionalism.)

3. We are concerned that much of these time-consuming activities have **meager evidence to support their value and efficacy** in improving patient care and, in impairing doctor morale, may ultimately have a negative effect. While the public may rightly demand reassurance that their medical professionals are fully competent, they may well fail to appreciate the unintended consequences on workforce vitality and availability of over-rigorous and often unproductive checking systems.

"Being a competent GP has more to do with attitudes i.e. a passion for lifelong learning, being very self aware and an astute self appraiser, a wish to provide high quality service to the patient sitting in front of them and to the community as a whole. These can be measured and easily identified!

Colleagues falling below standard in my experience, often exhibit arrogance, no real interest in life long learning and prove to be poor self appraisers."

4. We believe that there have been **unhelpful comments regarding the ageing workforce**. Older doctors make up a significant part of the GP workforce, notably in rural areas, and alienating them with increasing demands of accountability may see them giving up practice prematurely losing not only their daily contribution to seeing patients but the experience of years and a continuity of care which leads to patient-centred, economical practice. We question what evidence exists to suggest it is the age of doctors that is associated with increased risk of mistakes or poor performance. Are these really amongst the 'outliers' for which elaborate recertification systems claim to detect?

(It is worth remembering that high quality, economical care is based on strong doctor-patient relationships in which patients receive enough time from their GPs and their teams for the real issues to emerge, often avoiding unnecessary investigation and intervention. 80-90% of diagnosis is in the History!)

And who will pay for all this? Do we imagine that our patients will be happy to have the charge passed on 'for their safety' or will fee increases end up compromising the most vulnerable again, those who go without other things, carry bad debt records or don't make or keep appointments? (Now there's a good audit of a practice. How many follow up and analyse the 'no-shows'?)

In summary:

Positive experiences:

- We believe an annual Professional Development Plan with peer reflection is a good foundation for guiding learning and maintenance activities
- We value the opportunity for collegiality, and reflective appraisal with trusted colleagues
- Practice based reviews are helpful if provided with a view to formative change rather than summary sign-off.
- Having and being locums in practices are some of the best opportunities to maintain standards, giving and gaining opportunistic learning.

Experiences of doubtful value:

- We fear that the gathering of "good quality performance and outcome data" when applied to professional development is lacking in evidence for improving the global quality of General Practice care.

- We believe that Multi-Source Feedback, while excellent in principle, has failed to deliver useful stimulus for change or improvement in practice.

Other concerns:

- We are uncertain from where the staffing and time for the proposed recertification will come in an already depleted workforce.

- We are concerned about the cost to practitioners, both financially and in terms of time and energy, that will be incurred, to the detriment of patient care and access.

- We believe that identifying older doctors as being in need of extra monitoring is inappropriate, unfounded and actually insulting, and carries the risk that many may leave prematurely, as has happened overseas.

- We are concerned that in the past, when deficiencies in colleagues have been noted, the follow up from the Medical Council has been slow and unsupportive, somewhat negating the whole exercise of supporting the outliers towards safer reflective practice

We recommend:

- That note is taken of the impact on General Practice of overzealous monitoring and revalidation that has occurred in the NHS and that there are signs that the GMC are contemplating a retreat from this position, to support their workforce. It would be deplorable if our health service in New Zealand had to go through this cycle for itself rather than learning from others' experience.

- That more consultation is carried out with the clinically active General Practitioner workforce to elucidate what is valuable in a practical sense to maintain professional standards and to clarify which externally imposed activities threaten to have a detrimental effect on health care as perceived and experienced by patients and communities.

- That a higher level of trust is placed on practitioners' professionalism to identify their learning needs and to mutually support each other in their clinical care.

RNZCGP Registered Rural Peer Group 912:

Richard McCubbin	Howard Wilson	David Wilson
Martin London	Tim Fletcher	George Tripe
Gayle O'Duffy	Jo Scott Jones	Janne Bills
Trevor Walker	Grame Scrivener	Anthea Prentice

14 February 2017

Paediatric response to proposed recertification for vocationally registered doctors

- Vocationally registered doctors must participate in an accredited programme based on a set of requirements including performance and outcome data to identify individual development needs.
  Comments:
  Whilst it makes sense to link performance to a PDP, I am curious how the myriad of clinical activities we each undertake- all so different- can be quantified and calibrated. The college would have to do a lot of work to make something user friendly. It would be hugely counterproductive to spend more time thinking about personal development and recording it than doing it.

- Vocationally registered doctors must develop an Individualised PDP targeted to their professional development needs
  Comments:
  PDPs are of variable use. The majority of practitioners are going to be actively learning and you risk penalising them by tying them to activities in a PDP when taking up learning opportunities as they arise (especially in NZ) is crucial. Will I miss a training if it's not on my PDP? Will the DHB begin to limit my CPD if it isn't directly linked to my PDP? What if the opportunity to address a PDP area doesn't arise that year…? It seems intuitive that the vast majority of vocationally registered doctors are already making sure that the CME they do (and report via MyCPD) is aligned to their clinical needs…the only thing this new requirement adds is another layer of beauracracy and complexity.

- Each medical college is responsible for defining the knowledge requirements for their vocational scope of practice and incorporating these in their recertification programmes. These must reflect expected standards of medical practice inc those outlined in college statements
  Comments:
  I suspect the colleges are best placed to hold this but at what cost? The cost of funding this will come back out of the DHB funds that will divert funds from patients.

- Regular practice review (RPR) is provided by the medical college as an option to undertake on a voluntary basis
  Comments:
  I am not sure what the benefit of 'choosing' this would be. Would it reduce the reporting back burden for the next 5 year cycle? Is it really for those whose practice is beginning to be of concern? Are you then asking the College's to undertake a regulatory function that ought to sit with the MCNZ?
  Where do the MCNZ think the assessors providing the RPR are going to come from? Since they have to be external assessors who is expected to pay their costs? And where do they get their time from?

- Medical colleges will provide additional support for doctors when required.

Comments: again this looks like devolving a regulatory function to colleges when it ought to sit with the MCNZ for vocationally registered doctors.

- Managing the ageing doctor
  No I don't think the MCNZ should mandate activities at certain ages. We all age differently.

- Medical colleges collect and analyse data to evaluate for recertification
  Comment:
  So where does the MCNZ sit in here again? You describe it supporting continuous quality improvement but my worry would be you would stifle it with so much additional paperwork. MCNZ is also assuming the doctor is free to develop and not confined in their progress by conditions at work. Quality improvement relies on organisational support as well as individual initiative.

- **Other comments:**
  This plan looks very like the GMC model in the UK. What is the evidence that this is working well?
  This proposal is an unnecessary imposition for the vast majority of doctors who already leran and develop throughout their careers. It is not designed to detect the few doctors who are not performing. The time commitment is onorous and we will spend more time complying with reporting and assessment requirements than actually learning and developing. There is a dearth of evidence that this proposal will achieve its goals.

This feedback is endorsed by the following from Dept of Paediatrics H awke's Bay DHB:
Dr Kate Robertshaw
Dr Philip Moore
Dr Kai Steinmann
Dr Russell Wills
Dr Nicola Jordan
Dr Sarah Currie

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ✓☐ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ✓☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ✓☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
See below (regular practice review). Meaningful performance and outcome data will be hard to measure without a very significant investment of time by reviewers.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

No comment

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This might be of value for defining broad common knowledge requirements, however increasing subspecialisation and differences in practice are making it difficult to define more specific knowledge requirements. For example, laboratory haematology encompasses the fields of both transfusion medicine and general laboratory haematology, however in New Zealand most transfusion medicine is administered by specialists employed by the New Zealand Blood Service. These specialists have quite different knowledge requirements to more general laboratory haematologists. Likewise most general laboratory haematologists have little to do with transfusion medicine and do not require much knowledge in that areas for their day to day practice.
Within laboratory haematology, individuals specialise further, for example in coagulation, morphology and academic haematology (both research and teaching). Part-time employees will have a narrower comptenency range. We are all different. The diversity is necessary to ensure meaningful individual contribution towards a common aim of improving clinical outcomes. What we need most is the system that ensures collaboration and provides support in areas in which we practice. We don't need a complicated recertification system to tell us what these areas are.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

It is hard to see how this can be done in a meaningful way without investing a very large amount of time in these processes. This might be possible in specialties where performance/outcome data may be easily collectable, but in laboratory based specialities such as our own this could only take the form of some sort of comprehensive review of practice. Such a review is simply not practical in small specialities due to the limited availability of people who could perform such reviews. They are potentially very time consuming and at a time where resources are already stretched it is hard to see who would have time to perform them. It would also create problems in terms of maintaining consistency between reviewers and deciding what is an isolated error and what constitutes a more significant knowledge gap that requires remedial action. There is also potential variability in what reviewers deem acceptable. Finally in very specialised areas of practice there may not be anyone with sufficient expertise available to review practice in a meaningful way.

Many important areas of practice are already monitored by multidisciplinary meetings where diagnoses are reviewed; this would add an unnecessary extra layer of monitoring to these activities without adding anything to patient safety.

Overall, regular review of practice is likely to require very large resources for unspecified and uncertain gains. It is not clear that this will add anything to current recertification requirements.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

It is very hard to assess each others needs at the tertiary level, as they are unique by definition. At this level of career development, we can define what they are ourselves. The employer should provide equitable access to time and resources for professional development in all roles or FTE.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No, this would almost be discriminatory. These issues are best addressed internally.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of

undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?
This proposal is very vague and much will depend on what is required. It is not specified what data is to be collected. All this will take time and resource, which will be wasted if the data collected are not meaningful to the intended purpose of the program.
Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?*
The CPDP issues are best left in the hands of Colleges and employers. The emphasis should remain on a fair workload and making sufficient time and funding available to individuals to address their CME needs.
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
This will increase an admnistrative load, take up precious time and improve nothing.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Definitely not.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Group ✓ [redacted] **Do you agree to your submission, or parts of your submission being published**: No ✓ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ✓
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The principle of using doctors' performance and outcome data is sound. However the practicalities of doing so within a recertification framework are challenging. 1. If left to the individual the selection of what data to use might not address areas of difficulty or practice gaps but might be chosen to display performance in areas of clinical familiarity and comfort. If imposed from outside (e.g. formulated by a college) the data parameters may not be universally applicable. 2. Multisource feedback is increasingly popular but problematic. Selection of feedback sources, maintaining anonymity, formulating the feedback obtained and delivering the feedback in the right

context are all challenging. Multisource feedback done well requires expertise, time and **resources** which don't exist within financially challenged DHBs. Who will pay for the multi-source feedback to be done well?

3. Providing consistent "in-house" or "within team" formal peer review is challenging enough in busy clinical services under the pressures of health targets and restricted resources. Mandating peer review "*by peers external to the doctor's usual practice setting"* will be extremely challenging and likely impossible in many settings.
4. *"The minimum each year is a structured conversation with a designated senior colleague".* It would be very useful to mandate a feedback and development review for all employed SMOs but their clinical director, although a senior colleague, is unlikely to be considered 'external' to the doctors' practice setting. We are struggling to ensure all our SMOs have feedback and development reviews and a mandate from the Council, similar to the requirements in the UK, would be helpful. Those not employed could then arrange a"structured conversation".
5. The availability of performance and outcome data will vary dramatically between college craft groups, work-sites, services and teams. What does a doctor do in the absence of validated, relevant outcome data?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This part of the proposal has merit as it encourages "good intentions" to be documented in writing which can then be checked and revisited. However to be effective it relies on the insight and accurate self-awareness of the individual doctor to formulate a PDP which addresses areas of weakness or with room for improvement rather than reinforcing areas of current clinical competence and comfort. In addition extra time will be required to formulate a PDP and at present many senior doctors struggle to find any significant non-clinical time to address this kind of activity.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 3:
What is your view of medical colleges defining knowledge requirements?

The colleges are well placed to define knowledge requirements although there is a risk that the colleges will produce expansive documents which become as ambitious and unwieldy as some of the advanced training curricula have become.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Whilst RPRs can be a very effective tool and a learning opportunity in its own right for reviewers and the doctor being reviewed they are challenging to organise and conduct. There are considerable costs involved in conducting an RPR and it is not clear in the proposal where those costs will lie?
There is also limited availability of assessors. Even for Medical Council VPAs and competency reviews it can be difficult to find reviewers with the time to undertake these. These reviewers are the same people the colleges would want to use. The Colleges already put huge demands on their fellows.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Medical colleges are too removed from individual work places to provide the kind of individual support described here. This is the domain and responsibility of the employer's clinical leadership structure and this support will vary dramatically between workplaces. Direct involvement of the Colleges could well be counterproductive.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Medical colleges should take a lead in the discussion on this part of the proposal. However defining an age where certain activities are mandated will be fraught with problems. The factors (cognitive, physical and technical) affecting an individual's performance as they age vary significantly between medical craft groups. It is possible this could also be discriminatory. There are many non-age related problems which can cause doctors to underperform at any stage of their career.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

It is unclear from the proposal as to whether the colleges would be in some way responsible for demonstrating that continuous quality improvement has been achieved or whether they are required to ensure that quality improvement ***activities*** with a proven track record of achieving improved outcomes have taken place?
The data colleges are able to collect is summary data – they would not have the ability to analyse individual improvement activities. They may end up doing what RACMA has – in mandating that points are achieved by attending only college provided CME. This actually discourages SMOs from extending and improving – only assists them to tick a box.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

This is logical and consistent.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There are considerable barriers and challenges some of which have been pointed out in responses to

previous questions. There seems to be an assumption that medical workplaces already have mechanisms and processes for regular review of activity and performance underpinned by accurate and relevant outcome data and the proposals look to build further sophistication and detail into the system. Unfortunately the reality is that those processes are very patchy at best and that accurate data collection and compilation is not always available in a useful format to clinicians. The proposed recertification model runs the risk of stressing a faltering system and failing to deliver meaningful results.

On the other hand many on-going clinical review processes occur during the course of daily multi-disciplinary care e.g. tumour board meetings, joint ward rounds, shared in-patient cover arrangements, MDT meetings etc.. where performance of peers is constantly on view and constantly being reviewed. Knowledge of those kinds of clinical activities might provide all the information a re-certification process requires without introducing new measures and processes.

Ensuring that all employed doctors have regular performance review and are appropriately credentialed would be a better start – with parallel processes in place for those who are self-employed.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

This is overly ambitious.

[redacted]

Sent: Thursday, 9 March 2017 2:31 p.m.
To: Strategic Consultation
[redacted]
Subject: NZMC CPD Change Proposal
Attachments: NZMCcpdletter.docx

March 8th, 2017

Interested parties,

We have been very concerned about the change proposal from NZMC for vocationally registered doctors. I have outlined our concerns about the proposal and attached signatures from some SMO's with whom I have shared the attached document. Unfortunately, by the 'Guided Questions" section, it appears to be a fait accompli. I have had many excellent discussions with a variety of SMO's who all have similar objections and good feedback. This was especially true from my UK colleagues, who had nothing good to say about the system that the proposed changes is being modelled upon. In fact, the proposal is an almost carbon copy of the UK system that was done in response to the Shipman Enquiry.

In our discussions, it was pointed out that I do not supply any specific recommendations. This was intentional as I do not feel this proposal represents a step in the right direction. I do, however, feel it may be discounted by omitting feedback and would like to offer some here. I think it is very important for the Council to understand the downstream effects of the proposed changes. This is going to create many megabytes of data that we individually need to track. It's hard to imagine finding time to perform all the work we will be required to do for each other to satisfy the requirements. In order to perform these reviews properly, a considerable amount of time and effort will need to be put forward, otherwise it will be some onerous tick box exercise that provides no real benefit. In the UK there are now businesses that specialize in collating this information and charge doctors subscription fees. In an under resourced system that is struggling to meet the needs of patients, pulling clinicians away for even more hours of non-clinical work does not make much sense. Has there been a workforce analysis on how many more clinicians we will need to fill the gap?

In speaking about costs, I feel implementation of this scheme prior to a comprehensive cost analysis of a similar system would be highly irresponsible. There is an enormous amount of money spent by the General Medical Council in the UK, with a 2015 budget in excess of 104 million pounds, or 180 million NZD. While they administer the CPD for its members, instead of pushing the expense off onto the colleges, the cost by my estimate is on the order of 20-30 million dollars. 99% of the GMC budget is in paid physician fees. While there is little to no concern for the cost to physician in time, effort or money, this will at least in some part be transmitted to an increased cost in health care expenditure by the government and ultimately tax payers of New Zealand, when there is no demonstrable benefit. Currently, some physicians have a benefit of some professional fee being reimbursed by their DHB. With the huge amount of cost that will be generated to run this proposed system, I'm sure this will be negotiated out of the SMO MECA contract before too long. It is impossible for me to estimate the cost of lost productivity. I am at a loss as to why we are importing a bureaucratic behemoth from a failed system in the NHS. We clearly need an open detailed analysis of New Zealand's issues and solutions developed by and for New Zealand.

Individual colleges should be deciding what system is best for its members. For example, as an Emergency Consultant who specializes in the resuscitation of the critically ill and injured and spend most my time with these patients, the idea that I will be handing them a feedback form is quite frankly laughable if it was not so depressing. We are on the front line 24/7/365 taking care of patients who are at their worst, so I really don't think a patient feedback form is appropriate. I'm not sure of the goal, as it was not stated, in having a structured interview with a senior colleague that is not in my field of expertise. Considering I have high-level discussions with them each working day I am not sure how that would be useful, albeit certainly time consuming. A 360 review whose members are chosen by the individual's College and are

performed at appropriate intervals, as to not make an onerous system, no more frequently than every 5 years, may be of some benefit. Of all the recommendations, this one, if administered properly, may have some merit. Although not based on any evidence provided.

Thank you for your attention and kind regards,

[redacted]

_____
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Feb 25th, 2017

Response to "Consultation on strengthening recertification for vocationally registered doctors"

Dear Medical Council,

We read with interest the Council paper that was circulated 24 Jan, 2017 and wanted to communicate concerns and issues on this topic. Of the many proposed changes to CPD, the most concerning is in sections 1a, 2 and 4b in which there is a very broad recommendation that “at a minimum there should be outcomes from annual audits, along with multisource feedback (colleagues and patients) and also feedback from outside the doctor’s usual practice setting, with a minimum each year being a structured conversation with a designated senior colleague”. This certainly sounds quite far-reaching and onerous to perform with no offered evidence as the this being value-added to our practices or patients.

We have obtained as many of the papers referenced and would like to provide some insight and observations. It is appreciated that doctors in New Zealand are the most trusted group of professional as stated in the background, which would indicate that we must be doing something right. It goes on to then state, based on a report by Large to the Council, CPD is the key mechanism for recertification. Unfortunately this position paper, now 20 years old, is unavailable on multiple literature searches. We assume that it references the next 3 citations including what seems to be the lynchpin paper by Davis et.al. from 1995 titled 'Changing physician performance. A systematic review of the effects of CME strategies.' To summarize, this is a meta-analysis of data that spans from 1975-1994. Firstly, and probably most importantly, CME from this era cannot be compared to what is offered today. Davis' data collection were from studies that included "formal CME activities, outreach visits as academic detailing, opinion leaders, patient-medicated strategies, audit with feedback and reminders." and needed to only have 50% practicing physicians which included trainees. I'm not even sure what some of those terms mean and they certainly do not apply to today. I attended my first national conference 20 years ago and would have to say there is a quanta difference in quality of educational offerings. As opposed to the pre-internet era, there are now a large quantity of high-quality CME and information at our fingertips by world-leading physicians that are giving us evidence-based medical knowledge. I would have to say that the definition of CME that Davis describes simply does not exist anymore. Interestingly, the paper itself realizes that because of all the variability in the interventions "would have little practical meaning" and there was no change in outcomes, hardly a ringing endorsement of change. I think that Dr Davis and his colleagues’ paper put it well in the comment section:

“Do these trials represent actual physician educational experiences and settings? To a great extent they do not. Neither the complexity nor method of these studies were conducted match the learning and practice circumstances of most physicians. In addition, many of these trials experience a ceiling effect in studying volunteer physicians who are often performing at or near optimum levels. In the group, there may only be room for small changes that are difficult to detect. Moreover, these studies often use end points or outcome markers that may be selected more for their ease of determination (e.g. blood pressure) than their clinical imperative, such as heart failure or stroke. Lastly, the types of physicians selected as the focus

of these studies do not match the spectrum of today's US physicians. Few if any studies focused on the skill of surgeons, the clinical work of psychiatrists, the function of nephrologist, or other subspecialists."

The Council paper then goes on to state "doctors do not always recognize their own learning deficits and needs" based on a paper by Davis again from 2006 in which he rehashed some of the same data but now sourcing it from 1966-2006 and notes that the literature and data is "suboptimal in quality". It is stated in his paper, that these findings should be used for further research and he went onto hypothesize about possible different learning measures that while not validated, are currently employed by most speciality's CPD of which we are aware. While we cannot speak specifically to all CPD programs, we are all very satisfied with the robust educational offerings and the ease of documentation of our progress and activities through the [redacted] portal.

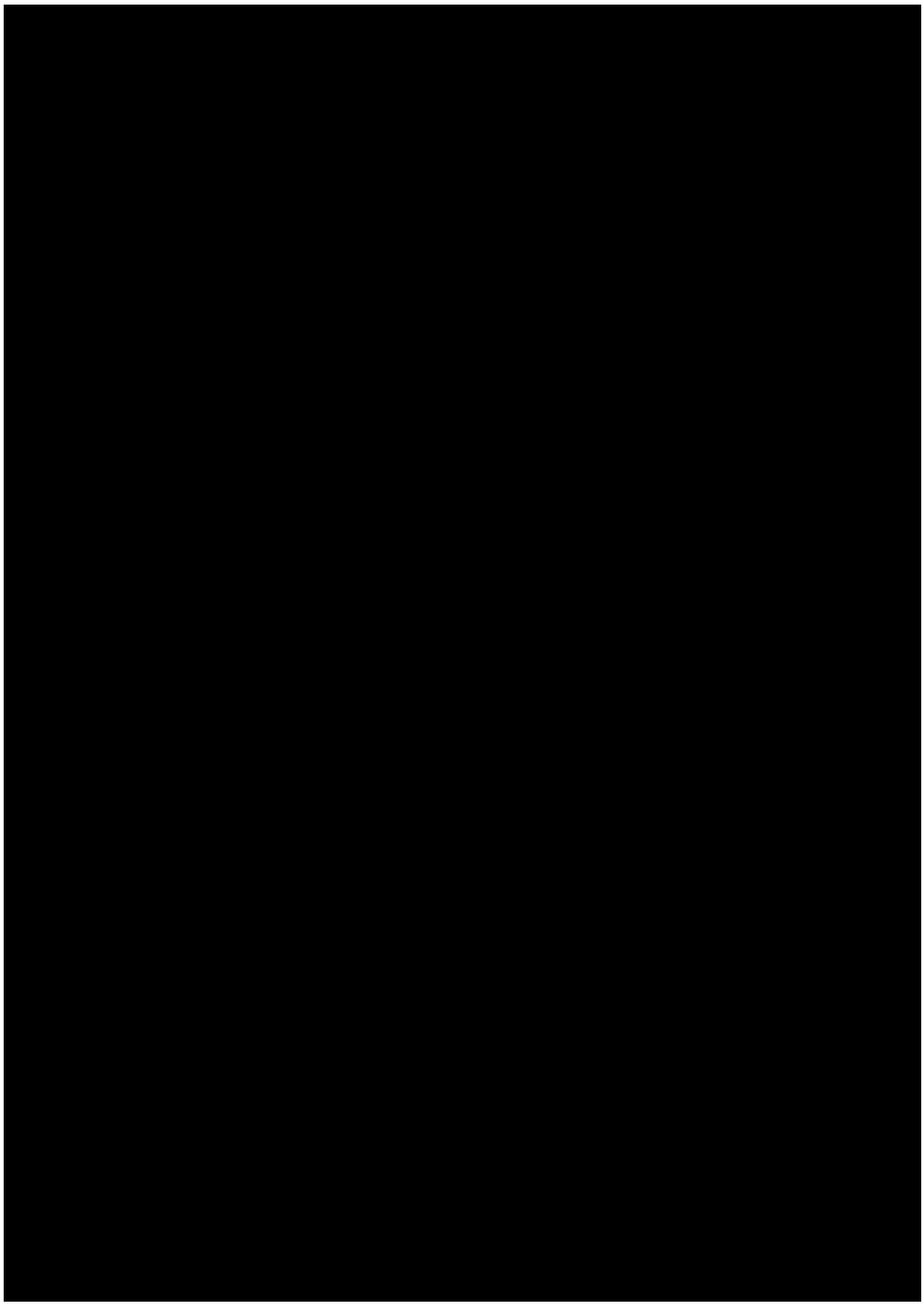
The last issue is related to decreasing performance with age. Suffice it to say, this paper has many limitations that are delineated on page 270 of the Choudhry article with which I would agree. Because of these limitations the author asks for more research and sagaciously points out " The effect of age for physicians who routinely collaborate with other physicians, who frequently engage in evidence-based discussions, or whose practices are influenced by disease management, performance feedback and computerized reminder systems may be different from that for physicians who practice in relative isolation or in more traditional settings." As very busy clinical physicians in an under resourced regional hospital system we would concur, and shudder to think of more onerous requirements.

Many important questions come to mind. Have downstream impacts of this decision been considered? New Zealand relies on foreign-trained doctors to fill the gap, contributing to 40% of the physician workforce. How will this decision effect this group and those considering taking a position? Will they decide not to come, or if they do, is it for a short-term avoiding vocational registration and involvement in their respective boards? How will new trainees view this? Is it just easier to fly 3 hours and work in a system that is better resourced, with pay in excess of double and having a much less onerous ongoing registration process? Most of our respective boards are based in Australia, which does not have this requirement. How is this going to impact them? There will need to be a special consideration and a considerable amount of work done around this change. Who will be paying for this? Finally, will there be senior clinicians that simply retire early to avoid all these requirements?

As a vocationally registered specialist working in a regional New Zealand hospital, asking us to do even more tasks and documentation to somehow prove we are worthy, is at best, disheartening. The idea that others, who have very little knowledge of me as a life-long learner or my practice, know better. Then also dictate how I should be learning is astounding. We have been tasked with an ever increased teaching requirement, supervision reports and documentation for house officers, registrars and other less senior staff over the last few years not to mention the myriad administrative duties. As an [redacted] specialist that is trying to match an ever increasing patient demand in a severely under resourced system, I find this initiative quite cynical. We are wondering why burn-out, depression, and disengagement are plaguing our SMO's, I think we all know the answer.

In summary, I do very much support best practice with continuing education and improvement. However, I do not think we should be aiming to put a system in place that is even more time-consuming and performing tasks that are not value-added to our practices. Finally, other questions also arise, who is going to assist with these measures and how much is it going to cost us in time, effort and remuneration? What is the impetus of this change? Is there an underperforming group that should be targeted, or are all doctors inadequate? Is there data to support change and if so, is there data to support THIS change? Certainly, the literature provided in this paper, did not.

Sincerely,



Antonia O'leary

From: Campbell, Craig <ccampbell@royalcollege.ca>
Sent: Tuesday, 16 May 2017 12:34 a.m.
To: Strategic Consultation
Cc: Campbell, Craig
Subject: My sincere apologies

Good Morning

The Federation of Medical Regulatory Authorities of Canada sent a request to the Royal College of Physicians and Surgeons of Canada to provide feedback on the recent proposal to set new standards for recertification programs in New Zealand. I was invited to provide the feedback from the Royal College in Canada and this simply missed my me. Today – when I re-discovered this e-mail I was dismayed to understand that the consultation process had closed in early March 2017.

I know this is too late and cannot be considered for this round of consultations but I thought I would provide some perspectives in the hope that this will be helpful to you in either the formulation or implementation of the changes that will be implemented in the future.

General Comments

1. The name – recertification – has been typically used to demonstrate that a physician is able to demonstrate they have sustained the competencies relevant to their discipline. Given that the educational strategies being employed by the Medical Council of New Zealand appears to be focused more on 'improving the practice of doctors relevant to their specific clinical responsibilities, practice and the heath service setting in which they work' – the intent of this program is more aligned with a practice-based rather than discipline-based educational strategy. I would encourage you to consider a more appropriate name for this program. We have struggled with defining an appropriate name that signals the intent of the Maintenance of Certification Program of the Royal College. One phrase that appears to resonate with the Royal College's senior leaders is Affirmation of Continuing Competence
2. We would support the need for physicians to develop a personal learning plan and for a mechanism to align the learning activities they complete against elements of both that plan and their scope of practice. We are developing a scope of practice tool that intends to a) describe one's practice; b) assess needs and c) then create a plan.
3. We would strongly support the need for a CPD accreditation system that establishes the educational and ethical standards for group learning and assessment activities. Whether the accreditation system is based on activities or providers is a decision that must fit the context within New Zealand. That said, there are definite advantages for both types of accreditation.
4. We also strongly support the need to engagement in assessment strategies that provide physicians with data and feedback about their competence, performance and the health outcomes of their patients

Specific Requirements.

5. Page 4. We would argue that outcomes from a clinical audit and multi-source feedback would provide the physician with three sources of performance data – from their peers and colleagues; patients and their performance. Adding a second external peer review as a mandatory element could be reserved for those who a) struggle to complete the basic requirements or who do so in a less than satisfactory manner.
6. The data that serves as the basis for the creation of a practice development plan should be accompanied by feedback – that is actionable, achievable and implementable by the physician. Providing data without feedback is not likely to lead to the level of behavior change that is hoped for or expected. The need for a 'structured conversation' re: career management could be expanded to help the physician 'make sense' of the data they have received.

7. The emphasis of the PDP appears to be on areas of professional development that require improvement. Although certainly acceptable the PDP could equally be used to foster improvement from competence to further levels of expertise even for those individuals who are performing well. The continual enhancement of practice as a goal for this program is something that will resonate with most physicians.,
8. We would support the need to review and revise the PDP each year.
9. We agree that completing CPD activities is an important part of any lifelong learning plan for practice.
10. Re: Accreditation standards – some programs will not be based on knowledge gaps but on other competencies that are critical for the delivery of safe and effective health care. We agree that all accredited programs must be based on an assessment of needs – of the intended target audience for that activity. In addition, we would require that the program translate those needs into learning objectives; select the appropriate learning methods and evaluate the outcomes of that program. There are a number of national and international standards for the accreditation of CPD activities that would inform the creation of the standards you are seeking to implement.
11. Regular practice review – as an option not a requirement is thoughtful. Regular practice review could be sought as a strategy by a physician; be integrated within work-based assessment strategies within a specific workplace and serve as a second wave of options for those who are struggling to meet expectations.
12. The Medical College in collaboration with the certifying colleges should establish a process by which physicians in practice 'learn new things' – such as a new procedure that was not taught in residency or where the technique for performing a specific skill has changed – new instrument, new approaches. Learning new things – before they are added to one's scope of practice – would require a plan to learn it and an assessment of achievement of competence before the individual is 'entrusted' to perform this independently (ie without supervision)
13. I appreciated the plan to work in partnership with the Medical Colleges – integrating their educational expertise and support to the expectations of a regulatory bodies who are working to protect the public. This partnership as described throughout the document is both reasonable and laudable.
14. Finally – the requirement to have a standard reporting system of those that enrolled, participating and who have completed their cycle is appropriate. This is a conversation that has occurred in Canada with the idea of 'good standing' as jointly defined by the Royal College, CFPC and FRMAC – as serving as the basis for reporting each year

Specific questions

15. The requirement to use performance and outcomes data to identify their professional development needs will be a challenge in terms of a) access to the data, b) its ability to enable them to identify learning needs and c) translate these needs into a learning strategy / plan. The requirements must be equitable regardless of vocation or practice context. Access to charts and patient feedback is reasonable to expect – at least to start.
16. The ability to develop a PDP requires a tool that allows users to align learning activities to a component of their scope of practice as well as their learning plan
17. We are supportive of the medical colleges developing knowledge assessment tools. However, given that knowledge is weakly correlated with performance, this should not be a requirement to pass (to maintain credentials or privileges) but an option that can contribute to one's PDP
18. Medical Colleges should have a process – guided by educational principles – for peer review. This needs to be safe and supportive and not punitive. One of the peer review processes – could draw upon direct observations in the work place; simulation; chart review etc.
19. The key educational support would be effective feedback. This may require a faculty development strategy around what elements constitute effective feedback
20. We would not support the medical colleges being tasked with collecting and analyzing data. This should be a responsibility of the health care institution where the data was initially stored. The outcomes of this assessment could be reported to the Colleges – who should define the detail of reporting required
21. The key challenges will be access to data and feedback to action
22. Three years is limited in relation to these new requirements – particularly if there is an expectation that the physician demonstrates improvement. We would recommend 5 years.

Finally – we are happy to collaborate with you, share strategies and tools, and consider options for scholarship and research in the future

Best regards

Craig Campbell MD FRCPC
Director, Continuing Professional Development, Office of Specialty Education
Directeur, Développement professionnel continu, Bureau de l'éducation spécialisée

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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☐ Group ×

[redacted]

Do you agree to your submission, or parts of your submission being published: Yes ☐ No ×
Do you agree to all or parts of your submission being published if it was anonymised: Yes × No ☐

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

As indicated in the Consultation Paper, doctors have a limited ability to conduct accurate self-assessments of their knowledge, skills, and performance. Without objective external feedback and outcomes data to support the creation of professional development plans (PDPs), such plans risk being misguided or incomplete. We believe that part of the purpose of using performance and outcome data in developing PDPs should be to help doctors target their improvement efforts towards those areas of their practice that are in the greatest need of improving. It therefore seems quite rational and reasonable to require the use of performance and outcome data to inform the development of PDPs.

In terms of having medical colleges assist doctors to use this data, we are not in a position to comment about whether these are the *most* appropriate stakeholders in New Zealand to fulfil the task. However,

we believe that assistance would be necessary for effective use of the data in developing PDPs. It would seem that the medical colleges would be well-suited to this end.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Requiring an individualised PDP for each doctor would seem to be the most reasonable approach to making improvement efforts most effective. Annual review of PDPs also seems like a reasonable timeframe. However, it might be the case that improvement processes will require ongoing measurement and intervention beyond this duration. The Council may therefore wish to communicate to doctors that while annual review of PDPs is required, it is perfectly reasonable for the content or subject areas included in a PDP to remain the same for more than a single year.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The medical colleges would seem to be in a position to accurately combine those expectations outlined by the Council with the subject matter of their respective vocations. This requirement therefore seems sensible.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

We are not in a position to comment on the feasibility of this requirement for the medical colleges

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

themselves. However, we see great value in RPR in that it provides an additional opportunity for external assessment of doctors' practice and could therefore enrich the set of data and feedback that could serve as a basis on which to develop effective PDPs.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The Council's acknowledgement of the benefits to doctors' improvement efforts that come through provision of support from multiple sources is laudable. Doctors' time is valuable, as is the service they provide to patients. Support for addressing their professional development needs will allow doctors to maximise value in time spent away from direct patient care more effectively.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

While career management planning would certainly benefit many doctors, we would recommend caution in terms of making any related activities mandatory. The Council may find that implementing content-specific educational requirements could cause physicians to shift time away from other endeavours, whether educational or otherwise, that also merit their limited time and attention. Perhaps requiring colleges to make such activities available and communicating this availability to doctors would be a sensible approach.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This proposal for the medical colleges themselves appears to mirror that which would be required of doctors. This therefore appears to be an example of modelling good behaviour. Medical colleges have a responsibility to those doctors enrolled in their programmes to ensure that the programmes are of sufficient quality to enable meaningful change and improvement in practice and patient outcomes. In the absence of ongoing evaluation, this would be nearly impossible to achieve.

However, just as doctors benefit from support in the use of their own data, the medical colleges may

benefit from more specific guidance about what to measure, how often, and perhaps also on baseline levels of improvement for their own programme outcomes. Such details could be specified in the requirements for continuous quality improvement in a similar way to the medical colleges' accreditation requirements.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

We have no specific comments, but feel that the programme standards should absolutely reflect the content of the vision and principles for recertification if these are to be components and underpinnings of the same system.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

While we are not aware of resource constraints on the part of the medical colleges, or implications of such programmes on dues or membership fees paid by doctors in vocational scopes, these would be relevant issues in our jurisdiction if requirements such as those being proposed by the Council were put into place. We feel that the Council has conducted a great deal of research prior to developing its proposals and has demonstrated both the need for revised requirements, as well as an articulation of their value. We would hope that expressing this value to doctors and medical colleges and using the relevant research as evidence for the need for these recertification requirements would help to allay concerns and might also justify any additional resource requirements. We also feel that doctors will appreciate the multiple ways in which sources of support have been built into the Council's proposals and this will likely contribute to greater acceptance among the profession.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

This seems to be a reasonable transition period, provided that an effective communications strategy is in place.

ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

20 March 2017

Philip Pigou
Chief Executive Officer
Medical Council of New Zealand
PO Box 10509
The Terrace
WELLINGTON

Dear Philip

Change in Medical Council Standards for Recertification of Vocationally Registered Doctors

Ian Powell has written to Andrew Connolly asking him to meet with our National Executive to discuss this issue among others. We expect that that conversation will be frank and useful. Thanks also to you Joan Crawford and Karen Davis for meeting with Henry Stubbs and myself on Tuesday.

Our National Executive has discussed your proposal and has some serious concerns. Our fundamental difficulty is that this proposal seems to be a solution in search of a problem. Neither the research you cite nor the research you have commissioned on practice visits demonstrates a problem with the practice of doctors in New Zealand or a problem with the standards required of vocationally registered doctors by any Medical College.

When we discussed this with you, you indicated that, though different Colleges were at different points in adopting the approach, all were open to and even enthusiastic about the approach to recertification that the Council was pursuing. You indicated that the Council saw this as a quality improvement approach rather than a quality assurance approach and therefore within the purview of the regulator's duty to improve competence. If we understood you correctly, in terms of the areas that you thought were most in need of improvement you cited cultural competence and informed consent.

Even given these concerns, we remain sceptical as to whether setting more onerous standards for Colleges to require of their members is the right approach to these issues or indeed that it is the proper role of the regulator to attempt to set standards which will undoubtedly become operational matters.

This would not necessarily be a problem if the changed standards you propose were without cost. In that event, they could be regarded as an experiment which could be monitored and settings adjusted in response to a less than favourable outcome. However, our view is that these reforms, once they work their way through the system, will prove to be very costly in terms of time, money and staffing numbers. As the Council will know, each of these resources are in very short supply throughout the health sector and additional costs should not be imposed without a rigorous costing of the additional resources against a realistic assessment of the likely benefits, which we suggest will be impossible to measure at least in the short to medium term.

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As has been well covered in our own publications as well as those of others the money spent on Vote Health has not matched needs for some time. The situation has worsened particularly since 2010. In our conversation, you indicated that both DHB Chief Medical Officers and DHB Chief Executives were of the view that the resource implications would be limited to redirecting money and time already spent. This seems overly sanguine to us. Certainly, some of these costs may be simply limited to redirecting money spent on CME. But the costs of practice visits, for example, will be passed on through various College fees by the Colleges to DHBs. Even more concerning is the extra pressure that this will place on our members who are already struggling to provide care to patients with constrained resources.

On a practical level, we would like assurance that the memorandum that you have with DHBs will make clear that the Professional Development Plan (PDP) will not be duplicated by a performance appraisal system or credentialing. You indicated that both the Medical Council and the Council of Medical Colleges had taken steps to ensure that was not the case. This needs to be made concrete in your memorandum with the DHBs.

We welcome your assurance that the Council will consider carefully also submissions on this issue and will, if appropriate, change its approach.

Yours sincerely

Angela Belich
DEPUTY EXECUTIVE DIRECTOR

4/1/8/17

New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

9 March 2017

Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143

By email: recertificationconsultation@mcnz.org.nz

Strengthening recertification for vocationally registered doctors

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest membership-based medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. There is a range of views on specific proposals in the consultation, which tends to reflect differences between colleges. Nevertheless, our association has a number of overarching concerns with the Council's proposals for strengthening recertification for vocationally registered doctors. We elaborate on these concerns in the following paragraphs.

2. We seek clarification on the Council's overall goals for the changes being proposed. For example, are they intended to identify incompetent doctors or to drive improvements in standards of practice? There is a widely held view that the Council has not made an effective case for the need for the changes being proposed. The proposed changes appear to be more about the regulator being seen to reassure the public rather than about actually identifying underperforming practitioners (if that is, in fact, the primary goal). The Council has also provided no evidence for the effectiveness of the proposals it is advancing. We are aware of various concerns with revalidation of vocationally trained doctors in the UK and the US. Before the Council's proposals

are progressed, we submit that it should clarify the objectives, review the literature on what has actually worked in other jurisdictions (if it has not already done so) and share its findings with all relevant parties.

3. The costs of some of the proposed changes are likely to be substantial. We believe it is incumbent on the Council, as the regulator, to provide robust external assessments of the costs of its proposals. This needs to include the work done by all parties concerned, including the colleges. We ask the Council to clarify expectations around who is envisaged to bear these costs.

4. It appears that the proposals represent a 'one size fits all' model. We consider this approach to be inappropriate, given the major differences between the colleges in size and resources, as well as types of work and work settings in which their members practise. For example, we note that the Council is proposing that each medical college will be required to provide Regular Practice Review (RPR) as an option for their doctors.

5. The NZMA has previously articulated its concerns relating to the proposed use of RPR to inform recertification. These concerns remain relevant. In summary, our main concerns with RPR include the following: i) this is likely to be a very costly process (in terms of both time and money); ii) to the best of our knowledge, there is no solid evidence of efficacy supporting this tool as a way of improving quality; iii) it is not appropriate for all doctors; iv) it may not accurately gauge a doctor's general performance.

6. While RPR may be feasible for some areas of practice, it is impractical for some colleges. We understand that the Royal College of Pathologists of Australasia considers RPR not to be feasible. We ask the Council to clarify what it envisages by way of RPR for colleges such as the Royal Australasian College of Administrators or the New Zealand College of Public Health Medicine. We believe that, even for specialties where RPR may be feasible, 3-yearly reviews would be unduly onerous; an RPR every 9 years has been suggested as more appropriate.

7. There is some ambiguity around the proposed new requirements for external peer review. For example, RPR is identified as an **optional** form of external peer review for individual vocationally registered doctors, but each medical college will be **required** to provide RPR as an option. We suggest that the proposed changes to the status quo be more clearly identified to make it clear to readers that the minimum requirement for external review is for a doctor to have a structured conversation with a designated senior colleague. We note that the Council is proposing that the structured conversation "could extend to RPR every three years". We seek clarification on whether the RPR in this instance is envisaged as additional to, or instead of, the structured conversation.

8. While we are supportive of using performance and outcome data from audit of medical practice to inform professional development needs, it is important to recognise and adjust for potential confounding factors. These long-established factors include:

- patient factors (eg, age, comorbidities, ethnicity, socioeconomic deprivation, health literacy, diagnostic validity, complexity/severity of condition)
- system factors (eg, diagnostic/interventional facilities, healthcare team factors, supervision, resources vs competing demands, management and governance)
- clinician factors (eg, volume of procedures, training, experience, and case-mix).

Failure to adequately take these confounding factors into account could lead to misleading information that does not reflect the actual competence of any individual named as lead clinician.

9. While there is general agreement on the usefulness of a structured conversation with a designated senior colleague in terms of learning, there are strong concerns about the proposal to link this (or RPR) with recertification. i) Peer review is generally most valuable when discussions between a doctor and a reviewer are free and frank. Such an exchange is more likely to occur in a privileged context. If the reviewer is expected to inform the Council of their findings, then it is questionable whether such a free and frank exchange will take place; ii) Confidentiality in any peer review scenario is of the utmost importance. If confidence is broken, disciplinary measures are warranted; iii) A structured conversation with a designated senior colleague may be open to abuse by colleagues. We submit that the senior colleague must be mutually agreed on between the doctor being reviewed and the college; iv) There is a widespread view that the proposed conversation with a designated senior colleague is unlikely to be effective at picking up practitioners who may be of concern.

10. We are broadly supportive of using the results from multisource feedback to inform professional development needs, but only if this is done well and collects feedback from the appropriate number of people. This exercise is likely to entail significant costs. There is also the likelihood of significant selection bias whereby people select only those they know will provide positive feedback. This is even more likely if the information obtained from such feedback is linked to recertification (and therefore, potentially to the person's livelihood). In order to elicit free and frank feedback, we believe that multisource feedback is best conducted in a privileged context.

11. We have concerns about the Council mandating certain activities as doctors age. Issues relating to ageing differ across specialties. It is our general view that cognitive assessment should be a continuous informal process for all doctors. Furthermore, a compulsory retirement age is likely to be unlawful. We note that a recent article on ageing doctors concluded that *"The best protection for all is not to further stigmatise ageing, but to have a robust and independent process of ensuring ongoing fitness to practice, which requires doctors of all ages to demonstrate that they have the requisite 'inherent' skills to practise medicine safely".*[1] The experience, knowledge, motivation and passion of an older doctor also needs to be taken into account; these attributes may surpass those of younger doctors and contribute to improved patient outcomes. We submit that further work is necessary to ensure retention of the value and contribution of older doctors while recognising and managing changes related to ageing.

12. We have some reservations about the proposal for all vocationally registered doctors to develop an individualised professional development plan (PDP) and question the need, cost, value and effectiveness of this proposal. While PDPs may be excellent for younger clinicians who are developing their skills, we ask the Council to clarify what its expectations are for an experienced expert, particularly when their audits are better than current published figures and they are content working in their limited field? We note that, as part of the proposal for PDPs, "each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement". This is very vague. We seek more details on this proposed requirement.

13. Finally, we believe that cultural competency is extremely important and should be incorporated in all recertification programmes. Rather than requiring individual colleges to develop their own cultural competency programmes, a single programme could be developed (perhaps by a third party) and then shared. Likewise, we believe that the NZMA Code of Ethics (and adherence to it) is fundamental to good medical practice and should also be incorporated in all recertification programmes.

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[1] Lillis S, Milligan E. Ageing doctors. Australas J Ageing. 2017 Jan 25.

We hope that our feedback has been helpful and look forward to learning the outcome of this consultation.

Yours sincerely

Dr Stephen Child
NZMA Chair

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **Name: Dr Mythily Ramanathan** **Position/title: GP** **Organisation: Self employed** **Do you agree to your submission, or parts of your submission being published**: Yes **Do you agree to all or parts of your submission being published if it was anonymized**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
There is certainly no need for recertification. **Doctors need strong support to maintain their professional developments and performances.** **Multi source feedback and recertification programmes are just waste of time, and will create another obstacle /bureaucratic system for doctors. Doctors will be spending most of their time to please staff and the multisource feedback reviewers…** **If someone is not in good terms with you they will give negative feed backs about you which is a human nature.** **Sometimes, multi sources can even write lies about a good doctor to undermine their practice.**

The performance can be identified by using patients' data and health indices.
Example: Using statistical data of vaccinations coverage, smear coverage, improvement in diabetes management by using HbA1C and other objective parameters in General Practice.
Also, the Data depends on the demography and this may not reflect doctor's performance.

There is no need for recertification at all. It will only create more work, waste of dollars and more obstacles and produce a failed system. Do we have any statistics to show that recertification helped? On the other hand, professional development is important but there is no need to involve medical schools. Medical school professorscan contribute and advice on professional development pathways, if requested by Medical council and the relevant Colleges.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Yes this is important, but no need to do PDP every year! This can be done every 5 years. Identifying the needs of patients and the practitioners in the community, is very relevant. This can be a voluntary activity, depends on the practice's own needs.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The relevant Colleges and the Medical council (doctors only, not the pseudo doctors) should be involved in PDP, not the Medical schools. For example, RNZCGP is responsible for vocational training of GPs. There should be only one umbrella to cover each vocational scope.

Proposal:

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

No need for RPR unless there is a concern for doctor's performance. Again, there is no need for Medical colleges to get involved. This should be organised by the relevant Colleges and Medical Council.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Yes this is important. This should be orgnised by the relevant Colleges and Medical council, not the Medical colleges. For example RNZCGP for GPs.
Regular educational sessions (yearly) and peer review meetings (6 monthly), are important.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Doctors above 65 years old should have regular educational sessions and peer review, and should work less hours within their capacity.

Proposal:

Performance assessment should be done by the Medical council if there are issues on a doctor's performance. Professional development and continuous educational activities are already in place and are organised by the relevant Colleges and Medical council at present.

There is no need for the involvement of medical Colleges.

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The relevant Colleges should be involved in continuous quality improvement. This should be done every 5 years to improve professional developmental activities. Recertification is not necessary.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Not supportive for recertification programmes. The doctors/Colleges will be spending more money to employ the staff to do this unnecessary task. The time and dollars can be spent for good patient care instead.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There is no need for medical schools to get involved in vocationally registered doctors' professional development activities.
Recertification model will create more financial issues and obstacles for doctors' performances,and also will create another failed system.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Professional development activities and continuous educational activities should be done every 5 years. Not supportive of recertification programmes.

Submission on the Medical Council's *"Consultation on strengthening recertification for vocationally registered doctors"*

Opening thoughts/comments:

This an individual submission, though I have discussed around these issues with several of my colleagues at the practice where I work. Some of their thoughts are echoed in this submission.

I wonder about the comment in the opening background paragraph that the Medical Council needs to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted. This statement is made directly after the opening statement that doctors in NZ are already respected for the high standard of care they provide and are one of the most trusted groups in NZ. If the opening statement is true then firstly I would question whether anything needs to change – i.e. does anything need to be "strengthened" when it comes to recertification.

Following on from the above, where is the evidence of recertification programmes having measurable benefits to patients? Does such evidence exist?

And where does the existing level of trust in Doctors come from. I certainly don't think it can be attributed in large part to the Medical Council's recertification programme – I think it's more likely due to the innate qualities of those pursuing a medical career combined with the rigors of undergraduate and postgraduate training and the strong traditions inherent in the medical fraternity (Hippocratic oath etc) that result in people/doctors with the enduring qualities to produce high standards of care. So, how much can this really be "strengthened" by fiddling with recertification? I do wonder.

In talking to colleagues (GPs) most already feel somewhat burdened by the existing recertification requirements. These things can easily turn into a box-ticking exercise, just another thing to be done amongst the myriad of things to be done.

My personal sentiments mirror those I hear from my colleagues' - I find myself spending an inordinate amount of time thinking about how I can meet the requirements of recertification on an annual basis – how can I get to that evening CME or peer review session? How can I find the time and money to attend that education session or conference? How can I find a cultural competence activity that stimulates me and is relevant to the largely white European demographic I work with every day?

Cost is another factor in the proposals being made (though it is not mentioned in the consultation document). Currently it costs me about $750 per annum in medical council fees, $1700 per annum for indemnity insurance, $1300 for Royal College of GP fees. To this can be added about $800 per annum if one attends a medical conference. So, about $4k per annum to continue to practice. Any increase in these costs would of course not be greeted with great delight by most. I'm not sure how other specialties compare to GP re these costs.

I suspect that a regular practice review system or structured annual conversation at the end of the phone would both add significant cost and paperwork/bureaucracy to current requirements. One colleague has commented that they are looking forward to retirement even more if such increased requirements are in the wind.

Some of the comments around older GPs are interesting and perhaps could be considered naive? Especially around the ability to pick and choose who one sees.

Regarding regular practice review: I work in a group practice (8 GPs) where we all work varying degrees of part time and thus all see one another's patients at various times. I think this produces a good degree of internal checking within a practice – i.e. if one GP practicing in questionable fashion this would be fairly quickly picked up. It also allows a high degree of choice for patients as to the GP they see and provides ample scope for 2nd opinions to be gained from within the practice. We also have an acute clinic that means patients can pretty much always be seen on the day and, again, increases the mixing-up of patient-doctor contact so that people almost inevitably see another doctor at some point.

I've suggested formal RPR within our practice or regular videoing of sessions but it has not been at all favourably looked upon – again, inconvenience and added time and hassle for all is not welcome.

Re professional development plans (PDP): The RNZCGPs already requires annual development of a PDP. And professional development activities are meant to reflect the completion of these plans. This is not always easy to achieve, in part because the CPD activities are not always readily available across the year to enable the fulfilment of the PDP.

Also, from a cost perspective, our practice at least does not provide time off or money for CPD activities. So the time and money come from our own reservoirs. I'm not sure how it is in other practices.

I don't want to sound overly grumpy or negative about the proposals but I (like those I've talked to) am very wary of increased requirements/time/money being dictated from on high unless there's very good reason and evidence that this will be of benefit to patients.

Onto specific questions…

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Actually being able to measure performance and collect outcome data of individual GPs practice seems like an incredibly difficult thing to do. I am not really quite sure what would be measured and how?

Sure, we have annual patient surveys at our practice of 100 patients and they generally come back with similar suggested improvements – e.g. it would be nice if you were seen on time and could always see the same doctor – unfortunately both of these things are incredibly difficult to control in the reality of day to day practice. But we take all comments on board and do our best.

We have also done some individual patient satisfaction surveys during GP training (50-60 patients). These tend to come back with generalities about the interpersonal interaction side of things, seldom with anything specific.

We also do annual reviews of our own records. These tend to highlight such things as better classifying and documenting things like smoking cessation and alcohol consumption etc – and I'm continuing to work on these things. But one can only do so many of these record reviews and you pretty quickly get fatigued by the process and I suspect end up learning or benefiting very little, especially with more and more years of practice under your belt.

One thing that could possibly be useful is peer review of notes/records, which we do occasionally do in the practice. It can be a slightly harrowing experience for all to have that level of scrutiny of what you've done and what you're recorded, but it's probably healthy. A requirement to do this twice yearly within a practice might not be unreasonable. However, there's also a reasonable amount of this that goes on in our individual peer review groups that we attend outside of our practice.

Personally, for learning and ongoing development, I find the peer group I attend outside of my practice probably the best forum for where this actually happens, apart from day-to-day practice itself – where learning is daily, highly relevant, and ongoing.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This is already a requirement from the RNZCGP (GP Royal College). Plans must be completed annually and reviewed/signed off by peers. So no change?

Question 3:
What is your view of medical colleges defining knowledge requirements?

Like question 1, I'm not really sure how this could be meaningfully achieved or put into practice. Medicine encompasses a vast body of knowledge. It would be nigh-on impossible to define what knowledge would be required for 1 week or another or 1 consultation to the next.
Then there are broader things beyond pure medical knowledge like what systems operate in particular geographic areas, for referrals etc – thankfully from this point of view more and more DHBs are providing *Healthpathways* sites that provide fairly clear management and referral guidelines for primary care to follow in a wide variety of situations. I would use these websites on a daily basis and I think that into the future they are a really important tool for ensuring best practice care is delivered.

This leads back into the clinical knowledge question again, because as a GP you might only encounter a particular presentation once a year, or once in your career - so you aren't necessarily completely well equipped to deal with something you rarely see. But, with *Healthpathways* in place this does help these sorts of scenarios quite a bit – you can quickly reference something and refresh on what to do.
If you are a locum moving through several DHBs I think it could be quite challenging to get to grips adequately with the systems operating in each place.

Also, there is the interpersonal interaction side of things – i.e. one might be book-smart and have all the knowledge in the world but if you can't actually get on with people and explain complex things simply to them then that doesn't make for a great doctor. And they might not come back. Problems/issues in this area may show up on patient satisfaction surveys, granted – so they could be useful in that respect.

So, in summary. I don't really know what this defining process would look like and I can't really see how it would be of significant benefit to anyone.
You could try and make general statements – e.g. about practising in a "culturally sensitive manner" – but this is so general as to almost be meaningless.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I think this could be a useful thing for doctors, perhaps once every 3 years would be a good interval. Additional cost could be a factor – I'm not sure what the current costs are of doing this?

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

There are a lot of doctors. Providing individualised support for doctors may well require increased staffing/resourcing by the GP College. This in turn would likely result in increased College fees payable by doctors – not desirable.
I'm unsure what this support would look like and I have significant doubts about whether it would or could make a meaningful difference unless (a) those employed to provide the support were adequately skilled/trained in this area and (b) the needs identified could actually met be met by available training/courses etc in any given year.

I do think that the conversation with a senior colleague on a periodic basis could have some merit. However, how would this be arranged? What would be the format of this structured conversation/review? And what would be the additional cost/time/administrative burden and churn created? Annually seems a bit too often to me. Perhaps every second year?

We already have an annual performance review process operating in our practice also, and I'm sure this is not uncommon in medium-large practices. So the proposed "conversation" could be a doubling-up in some sense for some people.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I don't like the tone of this proposal at all so I'd give it a fairly resounding "no". It seems to potentially significantly impinge on individual self-determination/choice in work and career. Also, as mentioned earlier I have major doubts about the ability to actually pick and choose who one sees to any significant extent in a general practice setting at least. You deal with what comes in the door, not just what you'd like to see or what's easy. This is part of the challenge and the attraction of medicine – the variety is endless. And what about a solo practitioner who's been living and working in a practice for 30 or 40 years – I'd imagine it would be pretty undesirable to suddenly be told you have to shut up shop and relocate into a larger practice – I'm pretty sure those patients who've been with that doctor for that time would be fairly unimpressed with this also – we are often getting complaints in our practice about not being able to see the same doctor. Patients value continuity highly. Convenience in terms of geographical closeness is also key in maximising accessibility/reducing barriers to care.

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Continuous quality improvement is a nice term. I'm pretty sure we are all improving continuously in an overall sense as we gain more experience/exposure and attend peer review and CME sessions.
However, in particular areas it's conceivable that we may not be improving - probably mainly due to a lack of exposure to various things. For example, as a male GP I don't think I'm as capable or assured in various areas of Gynaecology (women's issues) because I just don't have the same exposure to it as my female colleagues. But would it be reasonable for me to be seeking continuous quality improvement in this area? Personally I'd find it challenging to put time and resource into improving in some area (and there are multiple areas) that has little relevance to my daily practice.

General Questions:
Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?
Regarding the final bullet that recertification activities would/should be "supported by employers" – does this imply either or both of funding or time off being provided by employers specifically to fulfil recertification requirements? I know that hospital contracts

are fairly generous when it comes to time off and money to fulfil CME requirements but I think it may be quite a different world in a General Practice setting.

Regarding activities being “profession-led”. What does this really mean? Does it mean that requirements/activities shouldn’t be dictated from on high?

Re “Evidence-based” activities. I’d be very surprised if one could convincingly show the direct benefit of many CME activities. It’s just such a hard thing to actually measure or quantify. Does the evidence exist? – I’m happy to know about it if it does.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

As above, cost is always a factor. Who is going to pay for the potential increased administrative burden of the proposals. The attractiveness of the profession may also suffer. There’s the potential to push older practitioners into retirement even earlier if re-certification is made sufficiently difficult or people are directed (“mandated”) to only practice to a more limited extent etc. This would be very undesirable for the general practice context as there is a large proportion of older practitioners so if they start to bow out at a greater rate then the burden of care for those left could significantly increase.

Question 10:
Is three years from Council’s decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Firstly a strong case needs to be made for new requirements at all – is there actually a problem?

Ultimately I have sympathy the Medical council’s efforts in this area. We all desire standards to be high and maintained high. My feeling is that the standards are sufficiently high and the existing systems and processes are sufficient to help support them.

Antonia O'leary

From: Ron Baker <rbbaker@xtra.co.nz>
Sent: Thursday, 26 January 2017 6:30 p.m.
To: Strategic Consultation
Subject: recertification proposals

Dear Sir or Madam,

I do not see a lot of change in what you are proposing for vocationally registered doctors. I do not have a problem with your requirements for generally registered doctors but would not like to see those requirements extended to vocationally registered doctors.

For example I would feel insulted if I were required to have a "regular practice review" with another doctor sitting in on consultations and assessing my work. I work in a large clinic and am very experienced and highly respected by all the other doctors in my clinic as well as by the specialists to whom I refer patients, and I do an enormous amount of CME, mainly by reading. If your changes are basically not significantly affecting MOPS for the RNZCGP vocationally registered GPs then I am happy. But adding things like regular practice review (other than as an option) would be a nuisance, and no doubt a cost, as another doctor would expect to be paid for his or her time, and my College fees would rise yet again.

Keep it simple.

Regards,
Ron Baker
Three Kings Accident and Medical Clinic
Auckland

Antonia O'leary

From: Rex Browne <rexbrowne@gmail.com>
Sent: Thursday, 26 January 2017 5:06 p.m.
To: Strategic Consultation
Subject: Fwd: Consultation on recertification requirements for vocationally registered doctors

re
Consultation on recertification requirements for vocationally registered doctors

It may seem reassuring for NZ Medical Council to again "raise the bar" for re registration of medical practitioners.
But I suspect it will raise questions with many GPs - here are a few tha

t
come to mind:

- are the changes based o

  n

  good evidence of need, or

  just

  opinions from unrepresentative sources?

- do the changes ease our current administrative burden, and allow us more time for our essential medical information updating.

- are we really sure that the PDP exercise is of benefit? Is there evidence that it is useful ?
- how does this

  increasing commitment to audit

  fit with the reality of

  our

  diminishing workforce

  ?

- is it possible that the control and audit industry may itself be out of control?

I am, opposed to thi

s relentless

need to increase the
accountability

requirements on medical practice generally, and in particular

,
for
General Practice.

your sincerely

Rex Browne
GP
Devonport

FRNZCGP

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Rex Browne

Anne Street Medical Centre
29 Anne Street
Devonport
Auckland 0624

Antonia O'leary

From: Rose Laing <rose.laing@ccn.health.nz>
Sent: Thursday, 26 January 2017 10:41 a.m.
To: Strategic Consultation
Subject: Performance review by colleagues

On the whole, I consider that the reforms to recertification are appropriate and go a long way to making the process safer and more effective at supporting both patient safety and professional confidence and competence. I would like to know more about the suggested mechanism and assessment parameters for peer feedback about performance. My concern is that this has significant potential to be contaminated by hierarchical relationships, by dysfunctional relationships within teams and by collusion between colleagues who want to receive positive feedback themselves. How would solo practitioners in general practice or specialists in a narrow field or a small hospital, who have no local colleagues, access this sort of peer review? Would there be set criteria for review eg. In general practice would colleagues be asked to rate general competence, note quality, team function, patient feedback or contribution to practice CME etc? What would be the consequences of a poor review or a seriously concerning review? What would be the consequences of a poor patient feedback review matched with a glowing collegial review? How many colleagues would be asked for feedback? How would this be elicited and who would nominate the reviewers?
I realise that the mechanisms will need to be considered by the individual colleges, but wonder what the overarching principles of this aspect of the reforms are?

Regards, Rose Laing

Dr. Rose Laing | **GP Liaison for Older Persons Health and General Medicine**
Clinical Lead Collaborative Care
Canterbury Clinical Network / Canterbury Initiative
P: (03) 353 9970 or 021 242 1687 | E: rose.laing@ccn.health.nz
PO Box 741, Christchurch 8140 | 160 Bealey Avenue, Christchurch 8014

Antonia O'leary

From: Paul Riley <pwkriley@hotmail.com>
Sent: Wednesday, 25 January 2017 10:45 p.m.
To: Strategic Consultation
Subject: recertification consultation

My first thoughts are why is a proposal for strengthening being put forward before a review is complete?

Secondly, I seriously hope that this is not following the model seen in the UK, which has driven doctors into early retirement and emigration from an abysmal system of revalidation.

Kind regards

Paul Riley

Antonia O'leary

From: Kevin Gabriel <kevingabriel@me.com>
Sent: Thursday, 26 January 2017 4:45 p.m.
To: Strategic Consultation
Subject: Feedback on recertification

Hi Andrew Connolly - Chairman NZ Medical Council

I have some suggestions for recertification of vocationally registered doctors (VRD), especially pertaining to general practitioners

1 There should be the same requirements for VRD as general registrant doctors (GRD) specifically the 3 items below

- Complete the Essentials quiz (a knowledge test based on Council's statements).
- Undergo a regular practice review (RPR), every three years.
- Complete multisource feedback (MSF), every three years

I would be a better GP if I had to complete the above tasks regularly

2 There is too much emphasis on a PDP plan and racking up 50 hours of CPD - QUANTITY - rather than core/essential knowledge - QUALITY

At the moment a GP doesn't have to keep up to date in core areas, and easily gain required CPD points

A GP can create an easy PDP plan

My recommendation is that an Essential quiz (similar to Council's Statement)
- be applied the all critical areas of General Practice

I would have annual compulsory 5 online 10-20 question quiz with instantaneous feedback/answers and comparison to other GP answers
i.e.. 85% of GP answered this correct

There is no pass/fail for this

5 TOPICS FOR ANNUAL QUIZ

- BPAC Antibiotic Guide

- BPAC and/or MOH and/or Public Health Practice Updates

- Medsafe Prescriber Updates

- General Practice Emergencies - not just ACLS/PCLS

- Medical Council Statements

Then every patient in New Zealand visiting a GP, will be reassured that their doctor up to date with

- changes in medicine
- prescribing especially with antibiotics
- safe with emergencies not just ACLS and PCLS

At the moment they don't have this reassurance
A GP colleague at my work, joked and said that he hardly did any CME 1 year and gained enough CPD points by just taking medical students

3 Self Care for Doctors

In July 2004, the Royal Australian College of General Practitioners commissioned Dr Danielle Clode, a psychologist, to review the literature on the physical and emotional health of doctors. Dr Clode's review affirms that doctors "enjoy somewhat better physical health on average than the general population" but significantly lower levels of mental health, manifesting in high levels of work dissatisfaction, marital difficulties, substance abuse and "compelling evidence" of increased suicide risk, particularly for female doctors.

In a recent RNZCGP survey, 20% approximately of GP were feeling **burnout**

The incidence of **brownout** is probably a lot higher i.e. feeling disengaged or dragged down by work but not burnout

A GP is required to perform a clinical audit of patient records

How about turning the tables

Every doctor should be required to complete a self care audit every 1-3 years

4 Older Doctors

Older doctors are some of the best and worst/harming patients performers

The current system is too laissez-faire

I am all in favour of a GP working into age late 70s+ if they are mentally sharp - I have seen this happen

But I have also seen cases similar to the Gisborne **cervical screening pathologist Dr Michael** Bottrill

Mistakes and/or suboptimal practice in medicine are proportionately higher in younger inexperienced doctors and older doctors

Similar to car accidents per head of population being more common in younger teenage drivers and elderly drivers

Many professions have compulsory retirement at age 65 or less for obvious reasons + more stringent regular practice review e.g. pilots
- Pilots 65
- Emeritus Professors 65
- Partner Accountanting firms 55-60
- Partner Law firms 60-70

Suggestions

1 at age 60 every doctor should be required to complete standardised **Retirement future planning questionnaire**
- this would ensure that a doctor doesn't retire and then return back to work as they are bored or need more money
- this is not an uncommon scenario

2 Every doctor at age 70, should have to see their own GP to
- complete a medical to ensure they are physically/mentally capable of still practising
- this would include a **cognitive assessment**
- this should be completed every 2 years till age 76, then annually after age 76+

Note
- this is analogous to a patient seeing GP for medical for Drivers License at age 75

3 **Regular Practice review + Multisource feedback**
- should be completed every 2 years from age 70 till age 76, then annually after age 76+

4 No GP should be allowed to be a solo practitioner after age 65 - this a recipe for patient harm

5 Overall the standard of medicine/General Practice in NZ is very good
- previous HDC commissioner Ron Paterson said 95% doctors well performing
- 5% suboptimal
- 1% harmful to patients

I have lots of real life case examples to illustrate all the points I have suggested in this e mail
Am happy to discuss or be contacted in future

Kind Regards
Kevin Gabriel

General Practitioner
Westview Medical Centre
mobile 021 195 7051

Antonia O'leary

From: Dr Hammond Williamson <hammondw@fendaltonmc.pegasus.net.nz>
Sent: Thursday, 26 January 2017 1:09 p.m.
To: Strategic Consultation
Subject: feedback

I have very briefly read the information sent out about proposed changes to the re certification program. I am unsure what is changing.

The recertification process puts the onus on us doctors to ensure we comply “tick the boxes”. For most of my career I have done that and as a result have repeatedly missed critical learning opportunities which I viewed as important to me in order to fulfil the largely politically derived “goals” drawn up by others such as the RNZCGP. For example stopping smoking goals – I do it well but I do not record it as others would wish – so an audit using computer algorithms fails to see what I do.

I advocate simplifying requirements, removing the audit requirements (they are currently a sham), and just asking for a set number of points or hours per triennium. My view is unlikely to be given credence but consider this – at a time when it is hard to see a doctor for an appt and many are retiring it doesn’t sound good to tell patients “sorry your doctor is doing an audit so he can’t see you”. The huge imposition on our family life of meetings at night and weekends to comply with CPR requirements are a burden.

Kindest Regards

Dr Hammond Williamson, MB.ChB,Dip.Obst.,Dip MSM., FRNZCGP
Fendalton Medical Centre, P.O.Box 29013
Fendalton 8014
Phone 03 3515165
Fax 03 3517450

PS When on holiday or sick my email is not monitored. Hence if I fail to respond to email correspondence please consider directly ringing us for urgent matters. I usually reply within 24 hours.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The words all sound good – from the context of a single place of work. **I work as a GP locum. Peer review is difficult – who are my peers, how do I stay in contact with them, How do I audit the outcomes of my work, when my presence in a practice is transitory. What is a meaningful audit for a locum. These ideas will not work for those in locum practice.**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

We do this now. But much of what actually happens is spontaneous, dynamic and flexible. I see a patient who I am struggling with diagnosis or management. Reading and research takes place. I learn, I become a better and more experienced Dr. This process may be just a few minutes or it may take place over a longer time. This is real learning – but it is hard to record because often it is taking place in the chaos of a working day, with patients waiting and many other pressures. How do you record it. How do you note the Drs who don't do this – because these doctors are not learning.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Fair enough – if they and the rules that they are confined by (the medical councils rules) – allow for the wide diversity in practice style and form.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

This is meaningless for a locum

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

NO!!!!! This is ageism, it is offensive and its patronising. Its our job to make decisions about our careers and how we work.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Sounds good – How do you actually measure it in a meaningful way in general practice.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Remember that there is a looming GP deficit as GP's retire. Don't make it worse by making Drs retire because they can't stand even more bureaucracy and reporting – which is for the sake of reporting. You need to have systems that really enable Drs to continue to learn and develop. They need to be dynamic and adaptable to all of the different circumstances. I don't get that feels about these proposals. I just feel an enormous burden growing. At the moment we have to do 50 hours of CPD. For most this means 50 hours of our "free time", weekends, nights, when aspirationally we are also meant to be working on work-life balance etc. I understand the need for standards totally – but make the systems fit into busy work lives – make them meaningful and not a burden. I don't see that anywhere in the vision!
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
See above
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*

Antonia O'leary

From: David and Nicola Smylie <smylie@xtra.co.nz>
Sent: Wednesday, 25 January 2017 10:21 p.m.
To: Strategic Consultation
Subject: Re proposed new recertification requirements for vocationally registered doctors.

Dear Ms Davis,

It was with some dismay that I read the latest communication from Council, detailing proposed "strengthening" of recertification requirements for vocationally registered doctors. My first response involved the inclination to do what the vast majority of doctors will likely do on receiving your e-mail - hit the delete button, and try and quickly suppress the mixture of nausea, frustration and anger which such Council communications, nowadays, invariably inspire in good doctors across the country. However - although I feel fairly certain the Council will pay not the slightest bit of attention to the concerns which I am going to raise in this e-mail - I felt it was time somebody attempted to provide some sort of reality check to Council, which sadly seems to be becoming more a political arm of the government of the day, than true protectors of the public - certainly, Council seems increasingly to exist in its own ivory tower, divorced and aloof from the medical profession, and indeed seems to be becoming more and more adversary in its stance toward doctors. All common sense seems to have been lost, as Council attempts to be seen to be "doing the right thing": one can only deduce that Council members are more concerned about themselves - possibly to placate politicians and political activitists, perhaps to protect themselves from litigation, maybe to prove to themselves that they are doing something important and meaningful with their time on Council - than they are about doctors or their patients.

Firstly, a bit of personal background. I spent 5 years working very hard to benefit from a first-rate medical training at an excellent medical school in the UK. After house jobs, another 3 years were spent in specialty training for General Practice, on a top-quality vocational training scheme. I worked long hours in various hospital specialties, accumulating a huge amount of experience and benefitting from wonderful teaching given selflessly by the many magnificent colleagues with whom I was blessed to have worked. Before embarking on my career as a GP, I was lucky enough to spend time in more than one outstanding practice, and again was mentored by some true giants of the profession. I've worked in 4 different countries since then. I've sat and passed the MRCGP exam; I've become a Member and then a Fellow of the RNZCGP; I have the DRCOG; I've been Board Certified with the American Academy of Family Practitioners. I've taught medical students from the University of Connecticut; I've been on staff at Melbourne University. I've been a local rep for the RNZCGP. I've been a practice surveyor for the purposes of practice reaccreditation in Australia.

And my point is, there's nothing special about me. New Zealand is fortunate enough to be awash with excellent doctors. Doctors who, by and large, entered the profession with a desire to help people and to be the very best doctors they could possibly be. Doctors who work under extreme stress in busy practices, going above and beyond for the people in their care. Doctors who have many commitments outside their busy practices, both to their families and to various public and community groups. There is not a day goes by when we don't agonise over our many decisions. And there has never been a day gone-by when I haven't learned something about medicine, my patients and my care of those patients. We all reflect on a daily, if not quarter-hourly basis.

And that's what is so condescending about the Council's current stance with respect to ever more arduous reaccreditation requirements. In particular, the emphasis on the ridiculous "PDP" is especially patronising. Such plans are unhelpful and quite fanciful in the real world - there is absolutely no proof that they serve any purpose whatsoever - it is an (admittedly attractive)

fantasy to believe that they lead to any significant, lasting improvement in doctor knowledge or development (over and above the development which happens to doctors in the real world, anyway). They are, instead, just another irritation to the hardworking doctor - perhaps the Council doesn't realise what level of contempt most doctors have for such "kindergarten exercises". (Notably, in Australia, when the RACGP announced the introduction of similar measures recently, there was an exodus of doctors from the RACGP to ACRAM, who have a more realistic approach to reaccreditation. Sadly, in NZ, the Council and the RNZCGP operate a monopoly, so there is no alternative for doctors here; but Council should be wary of pushing the profession too far.)

I would beg Council to consider the potential harm which the ever-increasing and ever more arduous requirements are likely to do to the profession in New Zealand - in particular the damage which is going to be done to General Practice. The fact is, good doctors - potentially great GP's - are going to do something else with their lives, rather than enter a profession/specialty in which, in addition to spending most of their waking hours looking after patients to the best of their abilities, they are expected to devote increasingly unrealistic and unsustainable efforts to satisfying College and Council requirements. Surely Council is aware that quite soon we are going to have a very real shortage of GP's in this country. Good graduates need to be encouraged to consider a career in General Practice. Good graduates will not consider GP worth the effort if Council and College continue to make the specialty less and less attractive by smothering us all with additional mandated requirements (none of which has actually been proven to help anyone in any way). What we need are committed doctors who have a strong foundation in medical knowledge and a desire to do the very best for their patients. All your recent requirements will do absolutely nothing to help, or to change that fact; instead, the resultant shortage of GP's will truly result in deficiently trained and probably disinterested individuals being drafted into General Practice.

In the end of the day, Council has to be honest with itself. The question remains: why are you doing this to the medical profession in this country? The level of care provided by doctors in New Zealand is simply outstanding, already. I am constantly amazed and delighted by my colleagues. The vast, overwhelming majority of doctors working in New Zealand are simply magnificent professionals. Of course, there exist a few rogue doctors who slip through the net, and some - a tiny minority - who practise sub-standard medicine. Sadly, accreditation does nothing to root out these individuals: any deficient doctor can write an impressive "PDP", or do some form of quasi review of their medical practice.

I would submit to you that Council needs to work harder to uncover those deficient practitioners, and efforts should be made to bring them up to speed, or to bar them from practice in extreme cases. What you should not be doing is firing more "flak" to punish and demoralise the good doctors who form the core of the medical profession in New Zealand.

I beg you, in conclusion, not to steamroller through yet more impositions on the time and energy of busy and already very competent doctors. I appreciate that you see your crusade of recent years as being necessary for the protection of the NZ public. However, this additional "protection" is neither necessary, nor desired by the public themselves, and will certainly not be achieved by Professional Development Plans and Audits of Medical Practice. It will be achieved by high quality training of medical students and young doctors, ongoing quality CME for all doctors, investment in General Practice and allowing GP's to develop their art and special interests, as they have always done in the past. If you want a concrete measure of whether or not doctors are keeping up to date, then introduce a 7-yearly reaccreditaion exam, vis-a-vis Board Certification in the United States - that (together with the regular practice accreditation which already exists) will sort the sheep from the goats!

Most importantly, bear in mind the old truism: "IF IT AIN'T BROKE...!"

With kind regards.

Yours sincerely,
Dr David Smylie.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group □ **Name: Fiona Morris** **Position/title: Locum GP** **Organisation:** **Do you agree to your submission, or parts of your submission being published**: Yes X No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
As a locum it is difficult to belong to one single Peer group- or to even have one, if you are in isolated practice. How is this going to be addressed? **I am already a FRNZGP and do their requirements**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Covered by FRNZGP

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Covered by FRNZGP

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

If your career is as a locum, this is not going to work

Proposal:

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

That would be nice. As a locum with no set practice however, it would be difficult. The rest is covered by FRNZGP

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Does this even apply to locums?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I hope this includes the nuances of locum practice! Hard to see how though, as it sounds more clinic based

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

See above

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

See above- and below

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

I wonder if it is realistic. Sorry, to be a downer, but the number of foreign locums in rural settings (and now urban) is growing. These foreign doctors have different expectations of practice in NZ. They are here for a holiday or to move on to Australia (overseas) after certification.
If NZ makes it too onerous for foreign doctors to work here as locums or on short term contract, we will all suffer. I cannot see the short fall in rural settings, in particular the East Coast, North island and West Coast, South island to name two areas, ever being corrected. Increasingly, the gap will be filled by over worked nurses and NGOs.

Strengthening recertification for vocationally registered doctors
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You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

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Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Vocationally registered doctors do a lot of this with their portfolios already – you are adding a burden of extra unpaid work with no evidence it is needed.

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Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Again, where is the evidence this is needed?
For GPs – the list of topics that we identify we need to improve our knowledge of, and then do update our knowledge with CME is so vast – It would just be duplicating work with the CME – so ultimately pointless.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This is sensible, the problem will come when the RCNZGP definition excludes some work, so we have to stop providing it, and the hospitals cannot fund doing the work. Already in [redacted] we have a very patchy service for removing skin lesions – dermatology take 6 months, plastics say no, ENT say no. It is likely this would fall outside the scope of GP work as it should be specialist dermatology work, but they don't have the resource. GPs would then be doing work "outside of scope" and at risk of litigation.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

I see no benefit above CME
Proposal: **Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.** ***Question 5:*** *Do you have feedback about providing additional support for doctors depending on their individual professional development needs?*
This sounds sensible as long as undertaken in a supportive, no fault methodology.
Question 6: *Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?*
No, this is something that every professional should do, regardless of profession – should not be part of the MCNZ role.
Proposal: **Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement** ***Question 7:*** *Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?*
fine
Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for*

recertification programmes that align with its vision and principles for recertification?
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
If they are too onerous, a small percentage of the older doctors will retire slightly earlier than expected. New Zealand cannot afford this. If they impose an extra burden of work, the new part-time foreign doctors may be dissuaded and choose to work elsewhere, e.g. Australia. New Zealand cannot afford this either!

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐ **Name:** **Position/title:** **Organisation:** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
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This looks very time consuming. I have found with multisource feedback that busy doctors often don't respond to requests. I don't blame them. The only assistance we need from colleges is to streamline things as much as possible. For example regular practice review should include cornerstone visits from the RNZCGP. This hopefully would prevent double up. Cornerstone should ensure that all CME meets medical council requirements. So the doctors only have to report to one agency.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Is this evidence based? Does a PDP plan improve the performance of doctors ?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

reasonable

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

As long as it is a one stop shop. I don't want to be reporting to the medical council and the RNZCGP on the same stuff. I pay fees to both organisations and expect efficiency and collaboration and minimisation of waste.

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Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This is fine

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I don't think so. The silver economy data shows that many aging people are working well in their 70s. What the council should do is ensure that practices have an age friendly policy, rather than dictate to doctors what they can and cant do. Aged doctors have experience maturity, wisdom, reliability and should have conditions that reflect their experience and past efforts for the profession.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Again, cornerstone or college review should take care of this. I am loathe to endorse more activities that have doctors creating data for policy makers to use for their agenda . We are already doing a lot of useless and wasteful data entry so please keep this to a minimum.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Remember that job satisfaction and validation are some missing ingredients in today's neoliberal accounting environment. Don't measure things if there is no evidence that it makes a difference. You may be asked to show how your activities have helped one day.
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Burnout and the ideology that measuring everything means you can save costs. General Practice should have adequate funding as specialist colleagues do for CME and continuous quality improvement. These aspects of General Practice are now a cost burden to primary care. When you consider clinical load and responsibility and sheer volume of decision making, it seems reprehensible that there is not an allowance for this on equal par with our partialist colleagues.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Sounds reasonable

Strengthening recertification for vocationally registered doctors
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Performance and outcome data measures only a small amount of the work that a GP does. Even audit of things like diabetes control of my patients gives limited information about my skills because of all the other variables (patient and other clinicians for example) that influence the outcome. I work in a practice where it is rare for a patient to only be looked after by one practitioner. Our nurses work to the top of their scope of practice and as patients frequently present acutely may be seen by a different doctor acutely than their regular doctor. **Specifically for myself outcome data is probably impossible to gather as I do not have any patients who are "mine"; I see all the acute patients each day only (as I work half time in practice and half time as an academic. I am ambivalent about patient satisfaction surveys…many of our patients do not write English, we are significantly underfunded so the logistics of frequently running such surveys would**

often be low priority behind seeing and managing the patients. Multisource feedback is in my view valuable but only if it is done infrequently. The more times I am asked to provide feedback the less I consider and write on each one. I think the architects of these sorts of programmes underestimate the extent of "survey fatigue". The same applies to external peer review. In many medical disciplines there is a workforce crisis (sse NZMJ article on presenteeism and RNZCGP campaign relating to GP shortages) Requiring us to spend more time checking up on each other is time not spent providing care. I think we should be looking at systems whereby the contents of the recertification programme are significantly diminished for all doctors and that there is a targeted requirement for greater requirements either on a rolling basis or for particularly high risk groups.

Proposal:
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Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I find this satisfactory. We align it with my annual employee performance appraisal meaning that "two birds are killed with one stone"

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This is meaningless for General Practice. My guess that if you tested all GP's collectively they might hold all the knowledge you might want but that any one of them will have large holes related to the nature of their practice. I almost never instituted hormonal contraception as women tend to prefer my female colleagues and I do acute work. I know where to look it up if I need or more likely steer the woman towards one of my colleagues who does this well.

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Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I think this is a good option for those who wish to take it up and am pleased that it is not compulsory.

Proposal:
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Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I cannot see in what way the College can supply additional support, and you do not elucidate when this might be required and who might decide it is required. If this is about at risk doctors needing more oversight then this might be appropriate but I would see this as applying to a small number who have been identified by some disciplinary process. I think this sort of support is much more appropriately placed with the "employer" (a problematic concept for a sole practitioner)

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Making such activities mandatory would in my view be of dubious value. Many will be making such adjustments themselves without being forced to and a mandatory process would be just another hurdle to maintain registration without necessarily leading to any particular difference. Again I would see this as more effectively placed with the "employer"

Proposal:
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Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This is problematic because measuring the outcome of any programme is almost impossible…what would the control group be???? Therefore a lot of work on CQI would probably relate to surrogate endpoints and be of dubious significance

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I fear that the effect of raising the bar on requirements to maintain certification could have the perverse effect of leading to capable doctors retiring whilst still competent, at a time when we do not have enough doctors in many disciplines particularly in General Practice. I would like to see considerable work done on how to lessen the compliance requirements. I have been involved with a colleague's recertification process through BPAC. She works only in the university and has no patient contact. I find it bizarre that the medical council continues with the same approach they use for doctors seeing patients. I can think of no instance where this doctor might breech some requirement of the council that would not also be a breach of employment conditions.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The underlying philosophy of increasing the requirements for certification is an increasing lack of trust in my professional ability to practice safely. If the requirements are non onerous or things that I am doing anyway then I do not mind. I will attend my peer group anyway, Our practice regularly audits elements of our work anyway, my employer does an annual performance appraisal that aligns with a PDP process. If things are added in that have low evidence for making a difference (I would suggest patient satisfaction surveys fall into this category) with a high compliance cost, at a time when we are understaffed and underfunded then my confidence in the Council will fall significantly.

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?
Depends on how extensive the changes are.

Cameron Medical Clinic
1360 Cameron Rd, Greerton. PO BOX 3098 Tauranga
Surgery - Phone 578 2019 Fax 578 2751

Dr Ross W. Ogle
B.H.B. M.B. Ch.B Dip Obst
NZDSM FRNZCGP

Christine
PRACTICE NURSE

Dr Christopher Tofield
MBBS, FRNZCGP

01 February 2017

SUBMISSION TO:

Karen Davis
Senior Project Manager
Medical Council of New Zealand
P O Box 10509
WELLINGTON 6143

Dear Ms Davis,

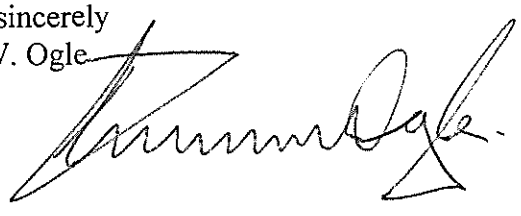
Thank you for the opportunity to make a submission to the proposed review of recertification requirements.

As a General Practitioner, I have no idea what recertification other Medical Colleges require, I am fully aware that the College of General Practitioners has for a number of years run the Maintenance of Professional Standards Programme that cycles over three years. All of the proposals suggested in your discussion document appear to be thoroughly covered by this programme, particularly the need for Peer Review, Professional Development Plans and Practice Review. I am therefore puzzled by the need for this review and by the opening comments, that "traditional methods of completing CPD have been shown to be of limited effectiveness". The documents quoted as 111 and 1V appear to be American Publications and perhaps not relevant to the highly organised Primary Health Sector we have in New Zealand.

You also state that knowledge and performance may also deteriorate as Doctors age, and there is a particular emphasis throughout the document, on encouraging older Doctors to limit their activities.

You will be fully aware of recent surveys that show 45% of all General Practitioners are now within 9 years of retiring age. The College of General Practitioners is hoping that a workforce crisis will be partially averted by encouraging older Doctors to continue working on after official retirement.
Your proposal to "strengthen recertification " looks intent on creating even more hoops to jump through on top of the 50 hours a year of unpaid recertification currently required. I would be most interested in hearing of any local evidence that this proposed programme is required, and in particular why it is necessary to encourage older Doctors out of practice. If I was to be undiplomatically blunt, I would suggest that:
a) the Medical Council is completely out of touch with the mood of the workforce, and
b) has too much time and too little to do

Yours sincerely
Ross W. Ogle



Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual x Group □ **Name: David Scharapow** **Position/title: GP** **Organisation: Cromwell Medical Centre** **Do you agree to your submission, or parts of your submission being published**: Yes x No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes x No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
GP college input should continue. I would personal feel happy for any peer or maybe the peer I use to review my PDP each year to have input. Mutisource feedback is fine but a lot of colleges feel this is a waste of time as often we are "sole practitioners" even if working within a large practice as no one sees how you interact and practice during your consults unless you do an RPR. Maybe something along the lines of GPEP video of consults as a vocational practitioner (with patient consent of course) that can be sent to your college for feedback might work

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I feel I already do this to a degree and have changed the format of my plans compared to the GP college suggestions as it is better for my style of learning

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

nil

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

GP college already provides this as an option to us but I have heard many GP's say they would like to do it but COST is a barrier. RPR's need to be affordable not thousands of dollars for some vocationally registered doctors on low income.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Good idea. I think a group that needs more support is the doctor returning to GP after significant time off whatever the cause and in particular those returning after personal illness. I personally have experience with this and after a period of 6 months leave following a health scare I found it difficult coming back into practice.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Maybe not mandate but maybe more a guideline for things to consider at certain ages. Bit like working out what scheme to go in for kiwisaver. Too much variation between individuals to set rigid rules and maybe guidelines for what stage in life or career you are in.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Nil- happy with current CQI requirements and would hope that most doctors over achieve above the minimum requirement for this

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?
Think about Cost to a doctor- both monetary and time. Hard enough at the moment to find money and time to keep MOPS current, especially for self funded GP's who don't get education allowances or funding from the PHO. There are many of us in this position. Ie locum GP
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Maybe not for General practice as the college MOPS online setup is excellent and probably already close to any new model so should be easy for them to update the website with new requirements
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Sure- would be happy with less as well

Karen Davis

To: Philip Harrison
Subject: RE: RECERTIFICATION OF DOCTORS - THE FUTURE

From: Philip Harrison [mailto:philip.harrison@hchc.co.nz]
Sent: Monday, 30 January 2017 12:09 a.m.
To: Strategic Consultation
Subject: RECERTIFICATION OF DOCTORS - THE FUTURE

Dear Sirs

I read the proposals for re-accredation and I have significant reservations about how the recommendations will impact on my Family Physician colleagues, as well as myself, as I am in the retirement phase of my medical career.

In March, I plan to leave my existing practice - one which I created from nothing in April 2010 and which now has 11+ doctors/12,000 patients, administers care to 4 rest homes, and provides one of the few walk in GP clinic for all patients. My own intention is to work a more balanced lifestyle as I reduce my hours and perhaps provide relief for colleagues who need regular breaks. I have been a practice owner, innovator, a GPEP1 Registrar Teacher since 2011, and a GPEP Examiner. I have also been an MCNZ Expert witness. I feel that I am well aware of the need for doctors to reach an appropriate standard of medical practice. I have not worked alone or unsupervised but with other colleagues. I have many weaknesses, always will have and I am still working on them!

Whereas, I am most happy to be scrutinised and assessed by the MCNZ and my College by way of my (not so senior) peers, the proposed other criteria for re-accreditation suggest that the requirements are progressing year by year. I do now believe they are becoming quite onerous; and may further encourage premature retirement in older GPs - when in fact — the Council and College need to promote their continuing engagement in (General) Practice.

Doing fewer clinics but a similar amount of accreditation creates an imbalance, a disincentive. Being peripatetic could well make the clinical-reaccreditation equation not worth the effort. Maybe the Council Members do not consider this a sufficient case for mitigation - fearing that older doctors may be loosing their skills and/or becoming sloppy in their dotage (when I don't believe there is evidence for this). The loss of senior GPs - 40% of the GP workforce in the next 10 years - from a diminishing pool of increasingly scarce and overworked GPs will further impact on the remaining GP workforce especially those who are newly qualified. This will impact on standards greatly. Overwork/stress is the biggest risk to professional standards. None of these procedures can be done without a major commitment in personal time.

So…

- If I am working in many practices, how might the multi source feedback be effected?

- How does a PDP help me (or you) when I am merely winding down, sequentially disengaging, assisting struggling colleagues as I phase out of full-time medical career into inactivity. Should lifelong learning be discounted in diminishing commitment?

- So if I choose to do locums as part of my retirement plan, and my clear plan is to eventually retire completely, why do I need a PDP? In addition, my locum activities will inevitably result in me providing only interim care as I will have no patients under my **continuing** care (which is not that different for doctors in hospital medicine and After Hours).

Of course, I can, and do, regularly attend CME and PEER reviews and will do more easily as I become less overwhelmed by clinical work - that is not a problem. But these activities seem now to be considered less important in the re-accreditation process when one ascertains from the points which are now allocated. Curiously, these were the things that reassured us that GPs (and other doctors) were keeping up to date. Does a PDP make a doctor more responsible than someone who goes to a PEER review group? Or attends regular CME? I don't think so. This is really a 'nice to have' document. It is arguably not essential to the practice of medicine especially in those who simply see patients and just need to become better at what they do.

I spent many years in public (government) service and industry where appraisal and PDPs were standard. They never once helped me evaluate any of my staff, but they did provide an opportunity for praise and/or admonishment, or more often discontent. Feedback from managers (including senior doctors) should be continuous and lifelong and not confined to annual assessments. Having sequential 1:1 meetings, minuted by the manager (and agreed by the reportee) I felt was always much more valuable. 360-degree allowed others rather than the manager to say what everyone already knew.

- In assessing altering 'case mix' - what is behind this question? What if the case mix has not changed? What if one only does clinical work (GP clinics) and nothing else? Is this simply a statement? Or am I perhaps missing something?

- Are their any examples of the sort of 'audits' the MCNZ want to see from a retiring GP doing locums? It simply creates a dilemma.

- Locations of work - as a locum is this not a simply a list of contractors one works for? Does this tell the MCNZ anything? How does this assess competence?

- And what if one has always works in a multi-doctor environment, how does moving away from that into an environment which is variable - and someone else - be assessed?

- If the MCNZ (or the College) organises an assessment of a specific doctor using a senior colleague will that doctor be expected to pay for this, or will it be covered by ones MCNZ or RNZCGP fee? These have already escalated over the years.

When new and quite unknown GPs come to NZ why do they only need to be assessed by a colleague using 3-monthly pro forma? It is here where a more thorough assessment needs to be made. Yet there seems inappropriate levels of assessment for those trained and working in NZ.

The increasing administrative workload in Primary Care - from all sources - really needs to be addressed as part of your maintenance of standards. GPs have 80-90% patient contact time compared to hospital doctors who have 40% or less. Full-Time GPs - often working many hours - must do most their CME, PEER review, PDPs, audits and the associated paperwork for the MCNZ and RNZCGP in their own personal time. Increasing this burden will simply diminish compliance, if in place of patient contact time it will reduce availability, and overall increase patient and doctor stress and reduce professional standards overall. And the increasing demands of patients by way of the H&DC is also impacting on doctors and takes up a huge amount of personal time and creates stress already.

I suspect some may disagree with my views but, in the end, I personally don't need financially to stay on as a GP and if I and everyone walks away from your criteria, MCNZ maybe causing more harm than good to our needy population. Then we need even more IMGs to fill the increasing gap, which sometimes creates other problems as many have unknown standards.

The re-accreditation process - post Shipman - this has become an industry which has taken on a new life over the past 15 years. It is hugely unpopular around the world and arguably has rather limited value to the public (but may make regulatory bodies feel more comfortable).

Are not the MCNZ re-accreditation procedures becoming more a cause of diminishing standards rather than creating better ones?

Philip Harrison
Family Doctor

HUTT CITY HEALTH CENTRES

Phone: 04 576 2009

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WAINUI: 5 Fitzherbert Road, Wainuiomata, Lower Hutt 5014 Fax: 04 564 3160

E-mail: philip.harrison@hchc.co.nz
WebSite: www.HuttCityHealthCentre.co.nz

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Antonia O'leary

From: Simon Spenceley <Simon@3rivers.co.nz>
Sent: Tuesday, 31 January 2017 4:34 p.m.
To: Strategic Consultation
Subject: PDP's

To Whom it May Concern

Why are PDP's still being considered a requirement for recertification? – PDP's are nonsensical, useless, academic constructs which bear no useful relevance to experienced practising clinicians – their completion is universally abused and their value is scorned on by 'coal face' clinicians.

Please remove PDP's from recertification requirements and make us do something useful and valuable for our personal development instead.

Simon Spenceley MCNZ: 35769
(GP – Gisborne)

Antonia O'leary

From: Donald Patterson <don-1@xtra.co.nz>
Sent: Wednesday, 1 February 2017 1:09 p.m.
To: Strategic Consultation
Subject: Recertification

It would be nice to think that there is basis in evidence for the proposed changes to achieve the desired outcomes. My experience is that the process is overly bureaucratic. I really enjoy the educational component of my work, but do not see the council or college as being supportive in this process. Education and maintenance and measurement of standards is important, the research that indicates that the current model is deficient, or that the situation is critical is lacking. I guess as GP's we will all just roll over and let the medical council impose its own agenda on us. There is no professional body that independently supports and represents General Practice. Sincerely Dr Donald Patterson

Antonia O'leary

From: Dr Shaun McKenzie-Pollock <shaun@nelsonfamilymedicine.co.nz>
Sent: Friday, 10 February 2017 2:13 p.m.
To: Strategic Consultation
Subject: Consultation document- Recertification of Vocational Registration

I am responding the the request for feedback regarding the Recertification of Doctors in New Zealand. I am a principal in a General Practice in Nelson. All our medical staff are RNZCGP Fellows and we undertake the rigourous process of Cornerstone accreditation via the College. At a recent local College of GP locality meeting, it was pointed out that there are doctors practicing in New Zealand as GP's who are *Doctors Registered in General Scope of Practice.* In our opinion, all doctors who are *General Practitioners* and in receipt of capitation-based funding via the Government should be under the the auspices of the Royal New Zealand College of General Practice. It would be incongrous if surgeons, anaesthetists or physicians were allowed to practice under the General Scope of Practice. We feel that a similar standard of practice should exist for patients of all General Practices in this country.

Yours sincerely,

Dr. Shaun McKenzie-Pollock
MCNZ 13212

Nelson Family Medicine

132 Collingwood Street
Nelson
03 548 0918

Antonia O'leary

From: Jonathan Simon <jonathan.simon@greencrosshealth.co.nz>
Sent: Monday, 13 February 2017 1:01 p.m.
To: Strategic Consultation
Cc: deanne.wong@rnzcgp.org.nz; Shaun Smith; Paula Polkinghorne; Alison Van Wyk - Green Cross Health; Andrea Stringfield - Green Cross Health
Subject: feedback on proposed MCNZ arrangments for vocationally registered GPs

Green Cross Health employs around 200 GP s and we have a real interest in understanding the likely processes around your consultation
There are a number of concerns

- We agree in principle to the recommendations in your discussion document
- We have concerns about the implementation that need to addressed with the results of the consultation
    - Who will develop a standardised, meaningful approach to practice performance data so that all NZ GPs are on a level playing field/PHOs/RNZCGP/GPNZ/a single competent PHO? An external organisation?
    - Who will pay for this development?
    - Who will deliver the nationwide infrastructure to conduct 3 yearly assessments on all VT GPs?
    - What will be the cost? (RNZCGP cost for Fellowship assessment is $3,000). I assume the cost for assessment will be similar
    - Our organisation has clinical leaders in each practice, these could be used (with appropriate training) to peer review other GP living in other areas, are you open to this?
    - Will this effect the MCNZ annual fee and if so by how much?
    - If a GP is found to have significant education needs and a remediation plan, who will oversee this and who will pay, what are the likely costs

It appears there are going to be significant increases in compliance costs for all doctors and that these costs will be paid for by all doctors, at the time the MCNZ releases it report, after consultation, it is important that all of the above issues be addressed.
I appreciate that a three year transitional arrangement is suggested.
It is important that the medical profession does not receive a drip of increasing costs over 3 years, we need to understand the cost implication of these changes
Best wishes

Dr Jonathan Simon ONZM | Clinical Director

GREEN CROSS HEALTH

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Private Bag 11 906 | Ellerslie | Auckland 1542

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Email: jonathan.simon@greencrosshealth.co.nz | www.greencrosshealth.co.nz

Because of what we do, everyone is healthier

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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual X Group □
Name: David Matthew de Lacey
Position/title: Doctor
Organisation: General Practice
Do you agree to your submission, or parts of your submission being published: Yes X No □
Do you agree to all or parts of your submission being published if it was anonymised: Yes X No □

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

To answer this and implement it one would need to know the real and verified documented national requirements; the scientific validity, the relevance, the accuracy of the data relating to each individual doctor. I believe this is impossible at the present time and imposing and depressing for the profession.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

These questions should be the province of the college not the medical council. It reads like an emotional political statement not a scientific statement.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

A large amount of these requirements are politically motivated and not medically motivated or relevant to the practice of medicine. There is no mention of patient responsibilities and doctors rights. The council's domains of competence. Does this relate to the testing of the medical councils competence as I would agree with that?

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

This is occurs far too often and is overbearingly expensive, and should remain an option only. Our cornerstone accreditation was very expensive and exhausting for our staff and disturbingly distracting from patient care. It should be once in a life time for a practice.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This is nonsense, Irrelevant and overbearing. A Doctor can always ask the College for help if required.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Age is a distraction and not a definitive factor for the ability to practice medicine Career management is a personal matter.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

What data and is it relevant, useful or helpful or appropriate?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

The standards for practicing medicine are the province of the colleges not the medical council.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There is a potential for losing a large section of the medical profession and create enormous problems for New Zealand with a shortage of doctors, disillusioned by the daunting requirements. The solution is not to introduce them.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

None of this should be introduced and would be detrimental to the practice of medicine in new Zealand. I believe the members of the medical council recommendations are paranoid, Mischievous and depressingly demonstrate meanness and malapropos towards the profession.

The Medical Council should offer proof of their competence, in the management of the profession and their qualifications for doing so.

The only redeeming feature is that you have asked for the professions opinion.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☑ Group ☐

[redacted]

Do you agree to your submission, or parts of your submission being published: Yes ☑ No ☐
Do you agree to all or parts of your submission being published if it was anonymised: Yes ☑ No ☐

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

We are already experiencing a massive increase in paperwork as a result of increasing compliance measures, patient expectations etc. This proposal will put additional pressure on the doctor, their practice & even the patients. As usual, with such proposals, the time & money needed to make this happen will lie at the doctor's & practice's door, not the college's. I also think there should be some autonomy as to ~~what~~ what a particular doctor wants to develop - in the situation of a large group practice there is room for some areas of subspecialisation & not a "one fits all" generalist approach of what a GP "should" be like

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Do not have a problem with having PDP per se, rather being dictated to what "has" to be on it

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Do not have a problem with this but think it needs to not be too didactic & allow for areas subspecialisation eg GPSI work

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I presume like all things that produce a lot of beaurocracy that the doctors will be those that foot the bill for the increased compliance in the way of increased fees. This is already an option in the RNZCGP's so hopefully this will not be the case

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

No

Question 6:
Career management planning is recammended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Studies on ageing pilots have shown what they begin to lack in adaptability they make up for with experience. Does the council have an evidence base to suggest this?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuaus quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This should happen & does with RNZCGP as far as I am aware

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Seems like an exercise in beaurocracy & "box ticking" anew - I am ~~CUTOFF~~ concerned about increasing pressure on compliance, data collecting etc which is already a pressure in everyday GP. Is there evidence that ~~recertification~~ non-compliance with, or inadequate recertification is becoming an issue to NZMC?

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

It would appear that the RNZCGP actually currently addresses all these aspects but if it is made more complicated/requiring additional compliance then the costs could be significant, both financially & to the life of the doctor who rarely gets a chance to have a good work-life balance as it is

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

[i] Institute for Governance and Policy Studies, Colmar Brunton. 'Who do we trust?'. Victoria University March 2016

[ii] Large RG, 'Maintaining Doctors' Competence. A report for the Medical Council of New Zealand June 1997

[iii] Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P and Taylor-Vaisey A. 'Impact of Formal Continuing Medical Education: D Conferences, Workshops, Rounds and Other Traditional Continuing Education Activities Change Physician Behaviour or Health Care Outcomes?' *JAMA 1999; 282(9);* 867-74

[iv] Brown CA, Belfield CR and Field SJ. 'Cost Effectiveness of Continuing Professional Development in Health Care: A Critical Review of the Evidence'. *British Medical Journal 2002;324 (7338)*:652-5

[v] Davis, D. A, Thomson M.A, Oxman A.D, and Haynes R.B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA: The Journal of the American Medical Association, 274(9), 700-705

[vi] Schostak J, Davis M, Hanson J, Schostak J, Brown T, Driscoll P, et al. (2010) Effectiveness of continuing professional development pro¬ject: a summary of findings. Med Teach;32(7):586–92.

[vii] Davis DA, Mazmanian PE, Fordis M, van Harrison R, Thorpe KE, and Perrier L. 'Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence; A Systematic Review'. *JAMA 2006; 296(9);* 1094-1102

[viii] Choudhry NK, Fletcher RH and Soumerai SB, 'Systematic Review: The Relationship Between Clinical Experience and Quality of Health Care. *Ann Intern Med 2005; 142(4);* 260-273

[ix] Lillis S, Milligan E. The Ageing Doctor. Australasian Journal on Ageing. In Press

Antonia O'leary

From: Doctor <torbaycommdoctor@ihug.co.nz>
Sent: Thursday, 23 February 2017 2:31 p.m.
To: Strategic Consultation
Subject: Consultation on recertification

I am unhappy with the consultation document. While well intended it has parts which are discriminatory. It provides ideas which do not appear supported by evidence.

As a GP our continuing medical education is provided by our PHO who arrange a series of lectures. Peer group discussions are provided throughout the year in which we interact with a group of colleagues. We have accreditation assessed by the RNZCGP which has turned out to be an exhausting process of compliance with a raft of abitrary standards which are often at odds with science, common sense and existing legislation. Without fail,any discussion with a colleague around this process brings up an ever changing summary of unnecessary and what I would consider abusive iterative process where people follow a poorly defined set of changing standards and are eventually afforded respite of being able to repeat the process in 3yrs. In this process there are elements of self and practice assessment, audit, systems check and initiation etc. There is no pressure on the College to encourage people into the profession or to maintain and support practices through this process. In summary our "bad performance" provides them with a whipping boy for which they take no responsibility. The PHO are more supportive and have learnt not to criticise the college of GPs inspite of overwhelming evidence to the contrary.

We have a HUGE load of compliance assessment which is ever expanding without need of it to be justified, doable, and fulfill the many functions that are intended. My comment really is make the College responsible for getting people through the process in a collegial way (note the word) instead of a power crazed punitive format at present. Make the requirements integrate with CME etc so that there is not duplication or clumsy addition tasks uselessly added to our admin load. I feel that GPractice is now a place to be avoided even though I love my work and patients.

Ideas like we do not know what we do not know etc are a little trite but do suggest a PDP developed by the practitoner will lack cover of these items ie organised lectures are useful . We tend to develop expertise in our areas of practice and not in areas in which we have little contact eg I do skin geriatrics and mental health. I do not do Maternity care due to prev bungled Govt attempts to exclude us and funding etc. There is an assumption that knowledge is what drives medicine and I would have to disagree in part. We have access to internet training, colleagues continuously. The practice of medicine is more based upon how we go about the process. Our training and our dedication to that. I have discussed with others that my patients regard the INFORMATION they get from the internet is KNOWLEDGE. A bad mistake which they make and also organisations such as Health Dept and your own make.

Any system is merely that you get what you measure and so good luck with that! I just think it should be rational, scientifically supported, recognise different practices including solo and integrated so that the work load is not enormous duplicated. It should support good practice and learning and it should "rehabilitate" those who err.

I have referred the document to the human rights commissioner as it refers to age, solo practitioners needing a supportive environment of group practice. I am insulted by this and your job is to assess our abilities not to judge us on style of practice or age.

You need to keep your cloth trimmed and your intentions clear or else I might be forced to parody the age and status of the medical council and I am sure you might feel injured by this in some way.

Dr P A Hunter

987 Beach Rd

Torbay

NZMC 12633

Dr Trevor Walker

Twalker.otago@gmail.com

0272243745

Dear Colleagues

My peer review group (912) have made a submission on proposed changes to the Medical Council's recertification requirement, which will impact on the College's MOPS programme. In addition to my peer group's submission I would like to add these three more general points.

Regulatory or collegial relationship

I was on the board of the College when it was considering if it should provide a reaccreditation programme. The board was wary the dangers of becoming a policeman for its members and losing the collegiality that the college members valued. After discussion, the board went ahead as we thought that it would be better if we ran the programme rather than having it imposed on us by an external provider.

In my opinion, it was the right decision at the time but now the downsides are showing. For many members, the only contact they have with the college is to fill in boxes for their MOPS programme. Although the college staff are supportive when members ring for help, in general the college is looked upon as the policeman for MOPS.

If the college is going to make changes to the MOPS programme, now is the time to promote appropriate, visible support around the modified programme. Collegial support in the way of resources and guidance should be the focus of the colleges contribution. Certainly, there must be some record keeping to allow members to demonstrate their commitment to continuing professional development and that they are continuing to maintain the attributes required of doctors by the Medical Council. However, the collection of records is not what a MOPS programme is all about.

Flexibility

Members of the College work under a great variety of circumstances. Some are general practice, rural practice, locums, sports clinics, after hours, administration, research, part-time, education, etc. This variety requires the College to take a flexible approach to MOPS.

Doctors should be allowed to use a range of methods to obtain for example: feedback from colleagues, feedback from patients, review of their practice etc… The variety does make it difficult for the College to present figures to the Medical Council such as "over 95% of our members have completed a standard Multisource 360 in the last three years". The unstated information is, however, that everyone scored over average! Some practitioners, I have met, perform standard tick box multisource feedback for reaccreditation but use other forms of multisource feedback to get feedback which is actually useful.

Putting flexibility into a system is never easy but it is likely to get better results. There are wise heads in the College who can think this through. It should be a priority.

Assurance of competence

I see that the Medical Council is proposing that recertification programmes will help assure the public of the competence of doctors. They wish each medical college to define the knowledge requirements for their vocational scope and incorporate this into their recertification programmes.

Measuring competence and knowledge are huge tasks and carry big compliance costs. One of these costs is moving time and effort away from patient care and consequent reduction in the quality of that care. I wonder what would happen if a poorly treated patient sues the Medical Council or a college for assuring their doctor's competence.

In my opinion incompetence is usually a result of:

1. Lack of commitment to professional development and

2. Failure to display the professional attributes expected of a doctor.

These are more easily assessed with less strain on the health system.

Finally, in your deliberations please remember *"not everything that can be counted counts, and not everything that counts can be counted"* W. B. Cameron 1963

Yours

Trevor

Dr T Walker

Antonia O'leary

From: Rebecca Randerson <beckanddave@xtra.co.nz>
Sent: Thursday, 2 March 2017 11:27 a.m.
To: Strategic Consultation
Subject: Brief submission thanks

Dear MCNZ,

I have read the consultation paper. I acknowledge the questions to guide submissions but don't have time to answer them in full.

Therefore I would like to submit the following;

" I am a business-owner/partner GP in an urban General Practice. Therefore I am representative of a number of NZ GPs in regards to being a small business owner.
My biggest concern with the proposal is what the phrase "has the support of employers" will entail. We can provide flexible work hours for ourselves and our associate GPs to attend to the meetings/requirements of these new requirements. However, I am concerned the increased requirements will bear increased costs. Hopefully there will be no increased fees for GPs despite the new system (most of us already pay quite a hefty fee to the RNZCGP every year, so we would hope that would be included within the RNZCGP fee). But if there are additional fees, we are not in a position to provide any funding for our employed/contracted GPs to achieve this - we would all need to self-fund as has always been the case. General Practice is continually being squeezed with extra expenses thrust on us without consultation (including IT initiatives forced upon us by government that are largely for the government's benefit) yet we are restricted by Fee-increase Regulation at the other end. Additionally we do not want to raise fees for patients as affordability is already a huge issue for many. "

Thank you,

Rebecca Randerson
GP, Churton Park Medical Care
Wellington

A RESPONSE: WITHOUT PREJUDICE, INTENDED AS FAIR COMMENT ONLY FROM MCNZ 39220

CONSULTATION ON STRENGTHENING RECERTIFICATION FOR VOCATIONALLY REGISTERED DOCTORS

Appendix 1
Guiding questions for submissions

Proposal 1:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.
Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any
comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this? The time consuming, misguided use of performanace and outcome data, multisource feedback and external peer review are overwhelmingly unnecessary and misleading. Collegial peer group meetings designed to illuminate perceived or possible weaknesses in practice are far more effective eg. "What we think is you should go to XYZ meetings or conference, update your knowledge in the sphere of Cardiology rehabilitation, and be a bit more sympathetic to patients with high needs or low resources". "Let us all know how you get on ".

Proposal 2:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.
Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year? The professional development plan is a childish managerial device that is of little relevance to older doctors who are fully aware of their own needs and the difficulties of achieving their own personal goals. It should be abolished in favour of a brief statement of intent.

Proposal 3 :
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.
Question 3:
What is your view of medical colleges defining knowledge requirements? Some professions eg Osteopathy offer a 5-day residential continuing education course annually. Rotorua GPCME and its South Island equivalent could offer a 3 – 4 day basis for this, with an extra 1 – 2 days specifics by MCNZ/RNZCGP/MPS either at that time or at another time. GPs do not like being told to learn what they know already, so MCQ or MEQ could be used to ascertain their weaknesses not revealed by a personal statement, and "brush up" skills offered.

Proposal 4:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.
Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their
recertification? Most clinical failures related to systems rather than individuals. Cornerstone is a major advance. However it is often subservient to management and business plans, and lacks the teeth to identify factors such as bullying, patient access factors and failure to identify and pursue health targets outside formal programmes.

Proposal 5:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.
Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs? Please see detailed commentary at the end of this submission

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply? My personal view is that older doctors should be allowed to move towards health promotion and disease prevention as an additional component to the consultation, using their intuitive knowledge experience and skill, and away from emergency management. Some become expert at minor surgery and within various specialties while losing skills and knowledge in other areas. Updating is a better carrot than proscription..

Proposal 7:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement
Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement? Continuous quality improvement for an experienced doctor is more dependent upon the working environment than on their personal knowledge and skill level. There comes a point in each person's career when they feel "enough is enough" simply because quality cannot be improved upon without additional resources.

General Questions:

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification? IT CANNOT BE EMPHASISED ENOUGH THAT QUALITY AND STANDARDS RELATE PRIMARILY TO THE WORK ENVIRONMENT. THE VAST MAJORITY OF COMPLAINTS RELATE TO THIS ISSUE. FOCUSSING ON PERSONAL SKILLS IS DIVERSIONARY. DOCTORS ARE LIKE RATS IN A CAGE. IT IS THE WORKPLACE THAT NEEDS REVISING, NOT THE RATS. The particular focus is on a FAR higher level of training and

experience for those in whom is vested inordinate power by Employment regulations. CEOs and General managers need to be able to see past the balance sheet, tick boxes, and heads through doors. They need a SOCIETAL view and HEALTH PERSPECTIVE rather than a simplistic, childlike, business and quasi-legal set of protocols. A professional social worker would be a welcome addition to most practices and an active voice for change.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues? See above.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements? No, but in order to achieve it the deadwood needs removing and DHBs, PHOs,MOH and Government need to get on board the Prevention and Early identification, early treatment, anticipatory and pro-active care protocols.

Kia ora koutou,

Ko Rawiri taku ingoa, he rata whänau kua pakeke kia 75 nga tau.

Kua tae mai au i Aotearoa nö Ingarangi ii te mutunga o te tau 2004.

Ko te tümanako kia hoki mai ai ki te mahi GP i muri i te matenga tinana.

Ngä mihi nui ki a koutou

GENERAL COMMENTS

Here are a few off-the-cuff comments that may help MCNZ. Some are critical and may even be off-hand, but they have been designed with constructive ideals in mind and these should shine through.

As with many managerial reports, the consultation paper seems to focus on informing people who and what GPs are, what they do and why. It is as helpful as a report by doctors informing people who managers are, what they do and why. Managers do not need to know about managers, and doctors do not need to know about doctors. We know it already. Producing a tedious managerial report is entirely unhelpful to improving quality, other than by creating a list of tickboxes. Tickboxes may be the start of quality, but they are only the beginning. Experienced doctors may need guiding and shaping, but they do not need tickboxes.

A glance at references for the MCNZ consultation paper, thankfully short, displays a lopsided legalistic and managerial origin peppered with outdated conversations of little relevance to New Zealand general practice. It can be seen chiefly as a managerial catharsis.

- Institute for Governance and Policy Studies 2016
- JAMA 1995, 1999
- British Medical Journal 2002
- Med Teach 2010
- Ann Intern Med 2005

- Australasian Journal on Ageing. In Press

Below I outline a view of the problem and its possible solution from a worm's eye view, with a view to strengthening the method of revitalisation and recertification for older doctors.

ASSESSMENT PROCESS

1. Review the doctor's CV.
2. Ask the doctor to outline her or his clinical strengths and weaknesses. Seek comments from practice sources – "do you agree with this, do you have any helpful comments ?"
3. Use an informal person-to-person interview in which the doctor is asked to give an outline of how she or he intends to bolster any perceived weaknesses. The responses should cover education, re-introduction into the workplace, and protected work environments that would be helpful.
4. Use modified essay questions (MEQ) intended to cover a spread of clinical modalities,
5. Use multiple choice questions (MCQ) intended to cover a spread of "PC" modalities (ageism, croneyism, nepotism, genderism, racism, religious prejudice – all particularly prevalent in New Zealand - and any other -ism's you can think of)
6. Use a specific essay question designed to elucidate a constructive GP approach to low income high morbidity families.
7. Use a specific essay question designed to invite practice techniques to steer patients and their families, colleagues and friends into areas of lasting health, rather than simply towards terminating a single presenting problem. Design such a question to invite the insight that this is a major way forwards in reducing the avalanche of secondary care overload, and taming the critical pressure on emergency waiting rooms in General Practice and Hospital.
8. Ask a doctor to complete an executive-style health screening report for a low-income Maori male in the logging industry, including choice of investigations and recommendations for the future, concluding in a summary of health issues and how to address them. Look for an awareness that such scrutiny is capable of promoting health in low income families

RETURN TO THE WORKPLACE

For this is required (a) an initial protected work environment (b) long-term changes in work environments to relieve the emphasis of short-term business plans in favour of long-term health objectives.

The initial protected work environment in General Practice would be similar to Registrar (trainee, GPEP2) environments, possibly with attendance at courses, but of variable duration according to individual cases.

Long-term changes in work environments are long overdue. For too long business-led protocols have dominated surgeries and led to an endless, sometimes overwhelming, flow of profit-making turnstyles instead of long-term health objectives. The GP consultation has become a quick-fix triage centre rather than a health centre, with patients treated dismissively as single item objects rather than individuals, families, leisure companions and work colleagues enmeshed in an evidential (Evidence-based) net from which they need extricating if the pressure on emergency and unplanned advanced secondary care services is to be relieved.

Whilst “opening Pandora’s box” may be seen as a disaster by many GPs, especially those in high morbidity practices, grasping this “bull” by the horns is the only hope of staving off disaster in the public funded health service. Such an action might temporarily increase overload in all sectors EXCEPT emergency sectors, with proactive endeavours designed to optimise health on an APPOINTMENT basis. In contrast to the current emergency overload, a Pandora overload would be controlled, plannable, bookable, and inexpensive. It goes without saying that since the majority of preventable morbidity lies with low income families, that is where the initiative should start for the greatest effect.

This is where older doctors, supplemented by the latest Evidence based protocols of anticipatory care, early diagnosis, prompt treatment and preventive measures can make the greatest impact, provided they are given a continuing care environment in which to operate. Older doctors are perceived as experienced, intuitive, sensitive, caring and trustworthy compared to the fly-by-night single-issue fighter plane processes operated by younger locums and newly qualified doctors. RNZCGP has patently failed to grasp this nettle, and in my view it is one that MCNZ is duty bound to address.

An extended SOAP or HEAPS daily record template is needed for all doctors, with emphasis on maintaining accurate Classification, Medication, Screening and other details as well as appropriate commenting on lab results, reports and incoming hospital letters to enable brisk risk triaging as part of the consultation.

SUMMARY

Older doctors requesting re-certification need to be processed to lose their “quick-fix” single issue consulting habits and supplement them with a range of health-directed protocols. Evidence based objectives and clinical updates can be acquired from a variety of sources – online, CME courses and conferences, journals etc. Inevitably they will benefit from updating.

Family based management protocols, preferably but not exclusively with ethnic dimensions, need to be developed into “windows of opportunity” in the consulting environment, rather than “business opportunities” in revolving door, turnstyle, abacus “heads through doors” systems of their earlier careers. Part of this development needs to include historic MCNZ pronouncements, MPS insights, and political correctness mentioned above (ageism, croneyism etc). The SOAP or HEAPS template needs establishing.

Protected work environments need establishing for re-certifying doctors, and a campaign needs initiating to show how business protocols can undermine health targets, with the converse being the case that consolidated health targeting can ease emergency pressures at all levels of the system. The promotion of health needs to supplement and dominate health issue management, with an emphasis on preventive and proactive care.

MCNZ 39220

06 MARCH 2017

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☑ Group ☐

[redacted]

Do you agree to your submission, or parts of your submission being published: Yes ☐ No ☑
Do you agree to all or parts of your submission being published if it was anonymised: Yes ☑ No ☐

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Why change what we are doing? We already pay huge $$$ to you. This is going to cost $$$. Surely the current system is ok. Any Dr of concern need to be assessed fully on an individual basis not this one fit all tick boxing

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

We do this already

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

That's fine.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RPR is a good idea

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

No. Good to look at individuals

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Don't spend $ $ & time changing current scheme. Pick up individual DRs if concern & deal w them early + with less input

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

As above

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Increasing NZMC & GP colleges fees!

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group ☐ **Name: C J Carney** **Position/title: GP** **Organisation: The Doctors Waipawa** **Do you agree to your submission, or parts of your submission being published**: Yes X No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Measuring outcome and benefit to patients in General Practice is almost impossible to quantify. The GP contract in the UK has a lot of targets attached which merely create perverse incentives and abnormally skew GP attitudes and practice away from what the patient wants to what the system wants. THIS KIND OF APPROACH IS NOT IN THE INTEREST OF PATIENTS. Much of what we do to enable and support patients is not quantifiable. Patient feedback and peer review are the ONLY aspects I would support. AUDIT is another thing that does not work for me. The most useful support I have ever had is to have practice based pharmacists to review and analyse my prescribing. This allows me to correct things I need to change. As prescribing is a major part of my work this is the most useful thing to have in place. *It does not help me to do one audit on some small aspect when I have so many balls being juggled in the air*

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I have been exposed to PDPs in the UK under the annual appraisal system and here over a period of well over a decade. I can safely and honestly say that IT IS A COMPLETE WASTE OF MY TIME. To sit and think of some aspect that you look at over a year – and yes I have seen the examples given does NOT help me ONE IOTA. Every week I come across things that I need to brush up on and improve and I have to do that IMMEDIATELY – spreading it over a year is a waste of time. PDPs are a concept borrowed from commerce and industry but they are of no use to me in General Practice.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Medical Colleges need to support and help doctors by making their programmes relevant to the needs of doctors. As far as GPs are concerned we have a lot of pressure on us most of which is beyond our control. This needs to be taken into account. As the GP workforce ages older GPs are becoming more and more disillusioned with bureaucracy and onerous programmes will merely push more into early retirement – see what is happening in the UK – NONE OF MY FORMER COLLEAGUES THERE HAVE WORKED BEYOND 60 YEARS OF AGE

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

This will only be practical if does not become another administrative burden.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This seems like a good idea

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

The less regulation and mandate the better – support and a supportive environment would be much better

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

What data is going to be collected and how? See my comments in question 1. As one GP put it to me last week – "With all the costs of registration and recertification it hardly seems worthwhile continuing". SEE COMMENTS ON AUDIT AND PDPs. Consideration in the case of GPs must also take into account all the extra work being DUMPED in general practice by secondary care WITHOUT ADEQUATE RESOURCE AND SUPPORT. Also all the time it takes for us to constantly pick up the pieces dropped by THE FAILURE OD SECONDARY CARE TO DEAL WITH THE WAITING LIST ISSUE.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Standards need to be reasonable and take into account the already heavy burden of work, outside of clinical duties, much of which is already not supported and adequately funded. We don't nedd more bureaucracy that detracts from patient care and does not help the doctor. As I have mentioned above PDPs and AUDIT DO NOT HELP ME AND MERELY TAKE UP TIME I COULD BETTER USE ELSEWHERE

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

SEE COMMENTS ABOVE. In general practice frequent short surveys of things like prescribing practice ideally on a monthly basis would be much more useful than audit of some single aspect once a year. OF COURSE THIS WOULD BE EXPENSIVE TO EMPLOY A WHOLE GROUP OF PHARMACISTS so I canimmagine that the CHEAP ROUTE OF DUMPING more work on GPs would be taken!!!!!

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

I suppose it would be provided adequate support is in place

[redacted]

Sent: Monday, 6 March 2017 7:44 p.m.
To: Strategic Consultation
Subject: Re certification of vocationally registered Dr

I support MCNZ direction here.Thank you for your work.

Nga mihi nui

[redacted]

Comments on MCNZ review of recertification programme and its implications for general practitioners.

1. Whilst this isn't within the direct scope of RNZCGPs response. A major issue I see working in a rural setting with a steady stream of locums is the problem of non vocationally registered doctors. These are people working with general registration, but working as general practitioners. These are people who have either failed the vocational registration process or have chosen not to become vocationally registered. They are often "outliers" in other ways as well with either personalities and attitudes which can make them more prone to have certain aspects of their practice which makes their general practice more likely to have deficiencies and potentially not conform to current best practice.
2. The annual audit of general practice. It is not at all clear what form this would take. It is very difficult to design a general audit of you general practice which reflects your ongoing competency and reveals deficiencies. The problem is that general practice has such a broad scope, yet some GPs have narrowed their scope of practice to have a semi-specialised area of practice, how do you define their deficiencies? The audit I have done recently was the medical record audit for cornerstone, but in no way did it reflect the quality or deficiencies in my practice.
3. The risk is that we will be obliged to do an audit which is time consuming, yet unproven. Are there any evidence based audits of practice which achieves the goals of RNZCGP vocational reaccreditation or MCNZ requirements?
4. Multisource feed back. I did one as a College trial early in 2016. It was similar to one I did in the late 2000s (360). They give glorified comments and reveal none of my deficiencies. I know my own deficiencies, I think I mostly acknowledge them to myself, and I endeavor to address them in my daily practice. These are not clinical deficiencies they are in my personality and practice habits. They are never revealed in any practice assessment I have ever done. I don't put them in writing in any practice review. I prefer to inwardly acknowledge them and work to manage them as best as possible to ensure they don't encroach on the quality of my practice.
5. The proposal to remove the completion of CPD activities to address the PDP. This could be beneficial in that it could take away our needs to document various CME and Peer review activities. However there is value in these activities – peer review for the opportunity to share all sorts of various events around our practice from clinical developments, clinic cases and management changes to ethical moral and personal dilemmas. Peer review has been a hugely enjoyable and supportive part of my practice since they started about 20 yrs ago. I think they contribute in a positive way which is immeasurable to professional practice, and it would be sad to see them slip away if they are no longer part of the requirements of "CPD to address PDP". I think some of the people who complain about them either haven't found the right chemistry in a group (though I think diversity is a key to their value) or they are the outliers who do not easily work in teams, and are more likely to become out

on a limb professionally and hence more vulnerable to complaint or poor practice. I think the value of CME – conferences, meetings etc is in the networking which occurs. It helps keeping us all in the mainstream.

6. The issue of an aging general practice workforce. It is important to maintain competency whatever stage in your professional life. This new system must not be bureaucratic, cumbersome or have aspects which require tasks to be done which are not shown or known to be beneficial to quality practice. All the profession will be disgruntled if it is; however the aging workers in the workforce, if alienated by this process will leave. What is known to be a looming workforce shortage could be tipped into a crisis if older GPs become disillusioned and on average retire earlier by say 5 yrs – from average 67 to average 62.
7. Primary health care provision is evolving into a team activity. Another potential weakness is the development of a recertification system which has an individualistic focus. It is possible to get some assessment of a doctors “team performance” from multisource feedback systems, if the right questions are asked, but at the same time increased weight has to be given to the team aspect of such a survey, to allow it to contribute to the professional assessment value of the recertification process.
8. How is the process going to be enforced? If there are areas of weakness shown up, how are the deficiencies going to be addressed in a constructive way? Is vocational registration going to be withdrawn? How are the various Colleges going to deal with it or be expected to deal with it, or will the MCNZ take over the process?

Dr Tim Fletcher
Westport
12/2/17

Antonia O'leary

From: ahrhodes@clear.net.nz on behalf of Alister Rhodes <ahrhodes@clear.net.nz>
Sent: Tuesday, 7 March 2017 8:22 p.m.
To: Strategic Consultation
Subject: submission

Dear Karen Davis ,

In the beginning a small group of enthusiasts in the college of GP`s set up examinations to belong to the College & requirements of ongoing education.This was essentially imposed on their colleagues .

They achieved recognition of General practice as a specialty.

In my opinion the current requirements for recertification are some what overkill.

They have always , to me felt academic & only tangentially related to real every day general practice.

While there is is some useful learning from some of the activities the Personal professional development Plan is one of the least useful features. Myself & colleagues simply dream up something to meet the requirements. To make it central & pivotal to the new requirements ,in my opinion is misguided & a waste of time. There is a great deal of important stuff in general practice that can`t really be measured.By concentrating only on stuff that can be measured you are using a very incomplete & distorted model on which to base requirements.

General Practice is a very broad field & to single out one or two things is completely artificial. This concept of Self Improvement is almost like a religion. Doctors always try to do better & don`t need this artificial structure.

What doctors really need is Life balance. Then they will be healthy & happier & be able to give out to their patients.

Doctors are subjected to many pressures & stresses.(ref to Royal college information on caring for yourself).My concern is that more rigorous recertification requirements will inevitably increase the doctor`s stress.

Burn out is a very real entity.The average age of GP`s is increasing. If it is brought in the more rigorous recertification will inevitably push doctors out.

One of the main things with aging is less stamina. By adjusting the work load doctors can continue to work into later life.

To consider mandating what older doctors may do is to be avoided & quite frankly is bordering on ageist.

The Royal college & increasingly the Medical Council are intruding in everyday general practice. The current recertifcation requirements are already quite enough.

Please listen to the feedback from GP`s & leave well alone.

Alister Rhodes

Antonia O'leary

From: Lynne John <lynnejohn@xtra.co.nz>
Sent: Wednesday, 8 March 2017 4:48 p.m.
To: Strategic Consultation
Subject: recert feedback

Submission- from Dr Lynne John Voc. Reg. Canterbury GP (MCNZ 14743); age 61. Have been a RNZCGP Registered Provider of Education -and "Cornerstone" Practice Administrator for my Practice for over 6 years.

Personally recently involved in 'Career management planning'. Opted to give up my long term GP Practice and work as a GP locum, allowing myself much more leisure activity time. Have opted to spend several months at a time out of the GP workforce in the next 3 years.

One of the drawbacks of current General Practice is the onerous, increasing, paperwork load. I applaud systems designed to increase patient safety and quality outcomes, but the requirements of auditing/reporting ('dashboard' support tools included) together with expectation of adherence to e.g.Healthpathways advice to expedite referrals, is becoming increasingly untenable. For every hour spent in patient contact, there seems to be another hour of clinical and administrative follow up – often with very poor remuneration. I am still aware of the discrepancy of income between GPs and Hospital Specialists which is dissuading our newly qualified doctors (who perceive more work, more admin, scary autonomy, less income) from entering General Practice. I am fearful that the well-intentioned proposals herein will further add to the stresses for the GP population, as well as being a very costly exercise. To my mind, we GPs are already enrolled in a comprehensive accredited recertification programme. Currently, I see much evidence of unpaid GP time (collegiate mentoring/monitoring activities) which can reduce the time and energy available for the doctor to give face-to-face, quality, clinical care. More of this may be 'the straw which breaks the camels back'.

Comments inserted below where appropriate in red-

Appendix 1 Guiding questions for submissions

Proposal: Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.
Question 1: Under the proposal, each doctor will need to use performance and outcome data (how is this data to be gathered for GPs? We already have some feedback on our lab testing/prescribing/referrals via Canterbury Initiative in my area. For surgeons, one could assess mortality stats or gather info on complications of surgery, but other branches of medicine don't easily lend themselves to data- gathering?) , multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this? RNZCGP runs a good MOPs programme now- how are they to be given such multisource feedback and external peer review, other than is currently utilised in Cornerstone Accreditation programmes?

I

Proposal: Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.
Question 2: Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year? Already in place for GPs

Proposal: Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of

medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence3 , cultural competence, and the Code of Health and Disability Services Consumer's Rights.
Question 3: What is your view of medical colleges defining knowledge requirements? Already in place for GPs

Proposal: Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis. Question 4: Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification? 3 Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism Already in place for GPs- but this is time consuming and expensive and I am not sure if its value is evidence –based.

Proposal: Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.
Question 5: Do you have feedback about providing additional support for doctors depending on their individual professional development needs? Already in place for GPs. Again, how is this to be funded?

Question 6: Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply? Its sounds like common-sense to do so, yet where is the evidence, and to WHAT activities are we referring? I have read some info on this via the RNZGP/MCNZ websites and have discussed this with my peers (GP demographic is mainly >55y in my area)- not sure we have developed any plan of action for ensuring aging GPs practise in a safe way!

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement Question 7: Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement? Already in place for GPs

General Questions: Question 8: Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

Question 9: Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues? Time/money/ inducing burnout in participants

Question 10: Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements? Yes, once the new recertification requirements have been determined.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to providefeedbackon Council's proposal to strengthen recertification requirements for vocationally registered doctorsby responding to the questions below.

Deadline for submissions:5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual x [redacted] **Do you agree to your submission, or parts of your submission being published**: No x **Do you agree to all or parts of your submission being published if it was anonymised**: Yes x
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan?What is your view of medical colleges having to assist doctors to do this?*
I think that the use of performance and outcome data to identify individual professional development plan will be a good idea. The medical colleges should support doctors to do that and provide more clear guidelines and resources to facilitate that.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Totally agree.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical collegesdefining knowledge requirements?

It outlines the proper standards and domains which is similar to the common knowledge requirements in the equivalent colleges in Australia and comparable health systems in other countries.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Keeping the RPR as an optional review is a fair choice.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

More available resources like online learning/education resources should be provided to match the individual's PDP.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No specific suggestion.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Nothing to add on the requirements .

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

None.

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
One of the challenge that some doctors may face is the time management to address the requirement and the new proposal as there is no equality in the time availability or the work hours among all doctors as some of them are working on full time basis (long hours) high medical and social needs area while others are working part time in less stressful situation or less busy clinics.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes.

Strengthening recertification for vocationally registered doctors
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You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☑ Group ☒

Name: Peter Cunningham

Position/title: Dr

Organisation: Kitchener Rd Medical Centre

Do you agree to your submission, or parts of your submission being published: Yes ☑ No ☒

Do you agree to all or parts of your submission being published if it was anonymised: Yes ☑ No ☒

Guiding questions for submissions

Proposal:

Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

A key to these types of change working is ensuring an intuitive connection to everyday work, a useable tool which keeps all information in one place and a simplification one format. My concern here is that the proposal is using a complex set of requirements (practice audit, patient feedback, peer feedback). These are using differing types of data,

some too subjective to give effective information.

In addition this information is in differing formats, making storage and retrieval difficult. For simplicity (and therefore useability and support for the system by doctors) I would prefer to see a focus on just one area of feedback only.

Proposal:

Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Professional development needs are most often recognised in our day to day work as gaps in knowledge. We need a tool which is simple, easily accessible and linked to educational modules such as BMJ Learning provides. There should be a frequency of accessing the tool which makes it an integral part of everyday practice. Previously formation of a PDP has been done as an infrequent exercise (annually), recorded in a place distant from everyday practice. In this form it's use is limited, difficult to refer to and record response to.

BPAC is also provides very userfriendly information which could be linked into a recertification programme. Already we have BPAC audits which inform regarding our performance in general practice but their information is underutilised.

Proposal:

Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

1 Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 3:

What is your view of medical colleges defining knowledge requirements?

The above standards of medical practice are useful but with one comment. "Domains" of competence is a concept which I have not found helful. Previously trying to fit developmental needs into these domains has served only to confuse and distract (eg scholarship and professionalism are abstract areas which do not fit easily with medical care, communication etc). Again I would favour simplifying the approach.

Proposal:

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Proposal:

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I do not think our colleges yet have the tools required for an effective asessment of an ageing doctor. This needs careful work to avoid alienation from a profession which is needing to keep it's doctors working.

Proposal:

Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Despite the Council's belief that it is a priviledge for the profession to self regulate I believe there is room for recognition of the professionalism of the vast majority of its workforce. We are regulating to the lowest common denominator. Would it not be more effective to reward achievement rather than encourage a point counting exercise which our CPD has been to date. I do not feel positive support from the Council. I feel more a sense of overbearing regulation.

I do not have a suggestion for improvement but I would like to see more creativity around regulation. A recogontion of our professionalism and generally very high standards.

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual..

[redacted]

Do you agree to your submission, or parts of your submission being published: - Only anonymously .
Do you agree to all or parts of your submission being published if it was anonymised: Yes.

Guiding questions for submissions

Proposal:

Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

At first view this sounds like a good idea. When looked at more closely and looking at the details of how this would work, the problems start to appear. Having moved from the UK, a similar system has been introduced there and officially you would think it has been successful. However experience there reveals several problems. Small

organisations have difficulty finding enough people to generate feedback. Feedback is easily identifiable due to writing style, phraseology etc. It is easy for MSF to be used as a form of bullying and to assist in manipulating a member of staff out of an organisation and just provides another tool for the powerful to manipulate the weak in an organisation, especially whistleblowers.

In large organisations it becomes meaningless as staff have no working knowledge of another's work other than to say they seem to be a nice sort of person.

The one thing it has been successful in doing is in generating a large amount of bureaucracy, creating a new industry in MSF and similar activities which increase costs for Doctors and has driven older doctors out of the profession into retirement. As long as your medical workforce is not heavily skewed towards the older end of the workforce, you should be ok, but if it is then you may precipitate a workforce crisis as they now have in the UK. The worst of the crisis in the UK is yet to come as I have many ex-colleagues who are planning to leave due to the huge rise in costs and the increasing bureaucratic burden.

Furthermore it restricts doctors following their interests and just having to follow what their parent organisations require which are usually dictated by cost. It is unlikely that Banting and Best would have pursued their research into Insulin under such a model.

My advice would be to not copy someone else's mistakes.

Proposal:

Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

There does seem to be an obsession with PDPs as the solution to educational planning. Most doctors, myself included tend to look things up and and learn them dynamically according to need. The situation is well stated in a military parallel in Helmut Von Moltke senior's writings that, *"No plan of operations extends with any certainty beyond the first contact with the main hostile force"* which is more commonly summarised as *"No plan survives contact with the enemy."* His nephew developed this further to create

a military system that was adaptable to rapidly changing circumstances in the field without the requirement for top down administration. It became a very formidable army.

Why is this relevant? Because health care operates in many ways within similar constraints with limited resources, with a rapidly changing environment, with a poor communication links to multiple practitioners. The alternative top down approach has been tried by the NHS and whilst it is financially efficient, it has a reputation for poor adaptability to changing needs of it's client population and frustrating its staff with Soviet style bureaucracy.

A PDP is essentially an attempt to create a bureaucratic control system of doctors learning aqnd put a central command structure in to align a doctors learning in with that of the parent organisation. It may seem efficient but the result is that doctors will lose interest if they are not allowed to pursue their own interests and if spontaneity according to need is not catered for. Any PDP that is made is obsolete as soon as the ink is dried and is rarely looked at again until the following year when it is due for renewal. Most doctors I know do not find it a useful tool to guide their learning, more another bureaucratic exercise that has to be completed annually that gets in the way of the work that has to be done. If it is brought in as a requirement then I am sure that it will be ticked as a box to be completed, but it will not make New Zealand Doctors safer, just more short of time. A few do find it useful and for them, they are welsome to use it as a tool. Let us all use what we find works and not be coerced into using a one size fits all approach that has only the benefit of being easy to administer.

Proposal:

Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This is OK however I would be wary of making this too prescriptive. It can easily become a rigid straightjacket. I would be happy with a set of basic standards that we

1Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

should all adhere to. Medicine moves to fast to make it too detailed in it's requirements and there is a danger that it could rapidly become obsolete. It must also not be used to stifle debate around areas of medicine that may be controversial.

Proposal:

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

My concern is that something like RPR will work where it is voluntary. The danger is that systems that are currently voluntary may later become compulsory and then lose their power for change. The ability of someone to make changes is dependent on their enthusiasm for the scheme they are involved in. If they are coerced, they are unlikely to put much effort into developing themselves and you will get poor results. You will get good quality doctors by encouraging them to take pride in what they do and to want to develop their skills. It is not done by testing. You cannot regulate your way to quality.

Proposal:

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor’s professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The detail is as always what is important. Customised support for doctors is always a sensible idea. Anything which assists doctors to stay practising at an appropriate level is to be welcomed. However what is not welcome is trying a one size fits all approach where every doctor of a particular age has to have more stringent regulation or constantly recertify themselves to keep doing what they have always done. In the UK I was having to

take more and more exams just to do what I had done for 20 years even though there had been no problem. For example, I was de-certified from taking cervical smears as I didn't take enough even though I had done this from student days. Apparently I was no longer competent. I would now have to spend half the year taking certificates rather than seeing patients. Don't make it a bureaucratic monster.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Absolutely not. Flexibility is everything. You cannot mandate for every doctors' situation, you will just create obstacles. Provide opportunities for doctors to do different activities. It would be sensible for sensior doctors to become more involved in management and education but they need a reduction in workload to enable this to happen. If you make a process mandatory for this group, you are likely to drive them into early retirement making the workload problem worse.

Proposal:

Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Quality does not come by ticking boxes or generating pieces of paper. It does not come by increasing regulation. The only advantage they have is that they are easy to administer. We should not be that lazy. It comes by people doing the job wanting to do it better and having the time to do so. W Deming stated that targets will be met even if it is to the detriment of the organisation setting them. This has proved to be true of the NHS which still seems wedded to them in spite of the evidence of the damage they cause.

Peter Senge pointed out that quality initiatives cannot be impose from outside but have to come from within and people need to have time to enable them to grow. You need to do something about the workload of doctors if you want to improve quality. There is plenty of evidence for that.

The problem with quality is that it is hard to measure. You have to show that you are a professional organisation and explain that and allow professionals to develop and not pander to the statistics lovers who want pieces of paper.

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I have no comments that align with the councils ideas for it's vision for recertification. I think it is a seriously bad idea. I think you are trying to recycle an idea that has been used in the UK that has been an utter disaster area and cannot for the life of me think why you wish to do the same here. Have you got too many doctors? This is probably the fastest way to get rid of them. It has worked in the UK really well and as I said earlier, the worst has yet to materialise.

Your role should be to encourage good practice not to compel. You cannot force people to be good doctors. You can regulate to remove bad doctors and state what you expect of good ones. You can set what you expect the Stateto provide in terms of working conditions and training needs in order to allow doctors to flourish. Currently the workload is too high. I have worked as a GP for 27 years in two Countries as a partner in one and a locum in two. Your workload is too high and drs are struggling. You should be doing something about this and REDUCING THE BUREAUCRATIC BURDEN not increasing it!!

Yes I am emphatic as you are making the same mistakes that they made in my old Country.

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Yes, most doctors hate the idea of the bureaucratic model proprosed. Similar models have been a catastrophy and New Zealand GPs will certainly vote with their feet. Will you cope with whole areas of New Zealand without doctors. My solution to you is to quote an old Chancellor from the UK. "When in a hole, stop Digging". Simply don't do it.

Similar schemes in the UK were advertised as not going to take much time. My first appraisal preparation in year one took 70 hours. It didn't reduce much in subsequent years. Trying to find people to do an MSF became a nightmare and that was in a Country with 70 million people. What do you think will happen here? You really have no idea how time consuming some of the ideas proposed will be. Not to mention the cost as all these things will have a cost to them which doctors will not get back.

You actually have quite a good system in New Zealand and some good doctors who are hanging on and trying to keep the place running. You need to encourage them. The UK has NOTHING to teach you. DO NOT COPY THEM.

Do something about the workload so doctors can have time to learn. Learn from the Junior doctors strike in both Countries, they were not wrong. They need suppport and want to learn and have time to do a good job. Look at Deming and Senge. They are the route to quality not this constant measuring of everybody.

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Completely unrealistic. I think the UK took 15 years plus and still made a mess of it. I think you have no idea of the level of bureaucracy you are planning to introduce. You are going to be processing multiple documents for every vocational doctor in the country every year on a scale of multiples to what you are currently doing. I really don't think you are aware of how much paper you will be drowning in, let alone the rest of us.

Expect to treble your staff and move buildings.

Who is going to pay for it?

Please find a Kiwi solution. Remember no-one else did ACC because no-one else was clever enough to think of it and are now mired in Law suits. Look towards the W.E. Deming route and his 14 rules and Senge Learning Organisations. They are harder, but tend to get the results you are after.

https://blog.deming.org/2015/06/adaptation-of-the-14-points-to-medical-service/

http://www.moyak.com/papers/learning-organization.html

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz

Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☑ Group ☐

Name: Sally Widdowson FRNZCGP

Position/title: GP Locum

Organisation: —

Do you agree to your submission, or parts of your submission being published: Yes ☑ No ☐

Do you agree to all or parts of your submission being published if it was anonymised: Yes ☐ No ☑

Guiding questions for submissions

Proposal:

Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

As a GP locum I have doubts about the validity of any performance and outcome data. There is a very limited choice of outcomes which can be reduced to data form, and these are not necessarily those areas of performance which need to be addressed. I feel it is de-professionalising to try to reduce learning needs to easily measurable parameters.

Proposal:

Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This is already done under the RNZCGP recertification programme. It has its place, but I don't find it particularly helpful.

Proposal:

Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:

What is your view of medical colleges defining knowledge requirements?

Seems reasonable.

Proposal:

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their

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1 Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

recertification?

It seems a reasonable option.
It should remain voluntary.

Proposal:

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

~~It's~~

It sounds great, but if this means that every doctor needs an individual college mentor it would be prohibitively expensive to implement.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

~~Not sure~~ No

Proposal:

Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose

of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Of course we all support quality improvement, but I'm not sure what you mean by "continuous quality improvement" (like continuous economic growth it is unrealistic) or how it can be measured.

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I think you need to be realistic and pragmatic. The language in your proposal is quite baffling at times & you have to remember that doctors are practising under many constraints. ~~Don't~~ Don't kill them with bureaucracy. Is there any evidence that these measures will identify poor performers?

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

- Cost - in both time, manpower & money to the colleges & hence their members
- Loss of flexibility; this can feel de-professionalising
- Increasing difficulty in implementation for locums, who are already in short supply & may just give up.

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Seems reasonable if you have sufficient buy-in

[redacted]

Sent: Friday, 10 March 2017 4:50 p.m.
To: Strategic Consultation

Dear NZMCouncil,
Thank you for your email. I do not think RPR with another doctor in with the doctors is warranted nor is it supported in studies. I think studies suggest this can be deleterious for G.Ps in various measurements such as unneeded stress, loss of income , desire to leave general practice etc If doctors can not undertake a structured interview with patients then they would not have graduated as this was checked at medical school . This skill will hardly likely to have been lost! In fact more likely to been enhanced . Subjective analysis by an observer automatically alters the normal process and can be wrong. The NZMedCouncil itself has been found to be wrong in its decisions by the NZ Court system proving wrong bias can enter such subjective analyses. It is the up keeping with current medical information by dr.s that is most important and insuring fail safe practices exist . This can be done by an audit of notes or chat with a doctor or even by a dr. answering a questionnaire re practice management. Info. Updates with internet or conference points can be done re educational needs [redacted]

[redacted]

From: PC Mailbox
Sent: Tuesday, 14 March 2017 7:44 a.m.
[redacted]

Dear Dr [redacted]

I have forwarded your email to the Council's registrar for review and comment.

Sharon Mason
PC Audit Coordinator

Medical Council of New Zealand | P O Box 10509 | Level 13 Plimmer Towers | 2–6 Gilmer Terrace | Wellington 6011 | email: audit@mcnz.org.nz| website: *www.mcnz.org.nz*

Due to earthquake damage the Council office has temporarily relocated. Please be aware this may cause delays in response and processing times of your request. Email access only no phone calls can be taken currently by PC staff.

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[redacted]

Dear Sharon

I wanted to make sure that this submission is read and so I am sending it to the Medical council as well as RNZCGP

[redacted]

12/03/2017

Feedback on CPD

[redacted]

PREAMBLE – (not immediately germane to question put re MOPS)

My vocational scope is General Practice

I have worked exclusively as a locum practitioner since leaving Auckland Hospital in 1994.

Over the last decade I have worked in Australasia as a General Practitioner and as a Senior Medical Officer in Emergency in both base and rural hospitals

I manage inpatients in rural hospitals.

In Auckland I now work only for White Cross

I have gained much insight into all aspects of medical care and the practice of many GPs and other specialists

I have witnessed widespread medical and surgical malpractice – particularly wrt to unneeded skin and knee surgery and other orthopaedic surgeries in NZ and Australia, general incompetence in Australia and manner of over servicing

All the above demonstrates current MOPS programs are failing in Australasia.

CPD programs need to be rigorous, examination and peer review based, and compel doctors to follow the most up to date evidence even if that means an immediate change of practice when new evidence comes to light.

The colleges have an obligation to inform members who are performing unnecessary surgery that they must cease to do so or face censure.

The MCNZ needs to be prepared to police the colleges and challenge out of date practice.

It needs to put in place anonymous feedback mechanisms whereby whistleblowers can express their concerns.

It would be highly disingenuous to suggest that fraud and patient mismanagement are not widespread throughout the Western world – with possible exceptions being the UK and Canada.

Financial incentive is a precondition for corruption and the latter two nations are largely free from funding bodies which encourage it.

An ethical practice component needs to be introduced addressing the private sector.

This would include the points raised above – with the addition of a section on excessive fees.

These are defacto encouraged by medical insurers and the ACC.

MOPS RECOMMENDATIONS

Requirements need to be presented concisely.

In General Practice the following could be retained – maybe with some modification

(a) Peer group discussions/review

(b) Learning modules

(c) Audits – these are reasonable – although clearly much more difficult for locums

(d) Acute life support

(e) The cultural module needs to include any culture relevant to the doctor. eg The cultural norms of the Middle East vs Western culture and so on.

Ammendments to MOPS

First-

The Professional Development plan adds nothing to MOPS and needs to be dropped.

I suggest it be changed to a more dynamic system which reflects how we learn and how we retain important information.

Most of my learning occurs on the job and this occurs via a variety of mechanisms.

It is tautological that doctors don't know what they don't know and cannot adequately predict their "future" needs in a medical landscape which is changing at an accelerating pace.

Thus the ability to rapidly source "up to date" information is more essential than any "plan".

The following represents my approach – and also that of many other doctors.

- Google – reference to NICE Cochrane and other data bases. Frequent reference wrt anatomy – in order to illustrate to patients where there problem lies. This has a dual benefit as my knowledge of anatomy is steadily expanded

- Colleagues – these may be immediately at hand – or remote

- In Australia I have frequently been the only doctor on site managing critically ill patients – there are excellent systems in place for off site assistance – essentially patient and resusc under camera – all machines visible.

The college needs to credit this proposed way of learning at a higher rate than any module or peer group.

Information is always far better retained when learning in the clinical setting.

Second-

The introduction of yearly examinations

Quantification of knowledge is essential – how else can the knowledge of a doctor be properly assessed?

Example of exam format

(a) - core emergency diagnoses - not to be missed eg Pulmonary embolus Subarachnoid haemorrhage Myocardial infarction (women particularly) ectopic pregnancy (I was presented with a "comical" letter from a FACEM advising me how to manage a patient with pelvic bleeding that he had seen 12 hours previously. I ignored his advice and performed a BHCG ……)

(b) Every other diagnosis that a qualified GP could be reasonably expected to make

(c) Therapeutics -

(d) Other

At this point my recommendations re MOPS cease – but I believe the commentary is relevant.

APPENDIX

One

Some time ago I asked the GP College how they new the MOPS program was effective

The response was a blind assertion – “it is”

I asked for the data which informed them it was so

“We don’t have any” was the response – I have the E mails.

This is the age of Evidence Based Medicine – and yet we have been subject to a program without quantified output.

Go figure – I would like to meet the brain(s) which put the above logic together.

Two

The MCNZ oversees the Colleges – of which there are 35 or so.

It is de facto proven that that the MCNZ and similar bodies throughout the world are incapable of being impartial.

This assertion may be greeted with irritation – but it is fact.

To illustrate but 3 incidences with which I have had intimate association which prove that this is so

First – the Case of Dr X

It was remarked during a meeting with other health professionals and those with a bureaucratic interest circa 2014 that Dr X had had a “previous problem with pethidine addiction”. Following this an extensive investigation ensued during which the allegation was dropped, 25 years of pharmacy and other records were trawled through, a practice conduct committee established comprising the “expert advice” of 3 doctors who displayed absolute dereliction of understanding of the basics of general practice.

Dr X was accused of prescribing diabetic test strips to diabetics and prescribing Kenacort injections in excess of recommendations for hayfever.

He was also charged with prescribing phentermine for weight loss and pethidine to a single patient with monthly migraine.

No matter that the alternative Subitramine introduced in 2000 was found to kill people and that phentermine had an unassailable safety record.

He has been exonerated

I have been compelled to write Class B Controlled Drug scripts for him for over two years as this privilege was removed (voluntary undertaking). This has not yet been revoked.

The cost to date -circa $250,000

How it is that a Committee could adjudicate that the prescribing of diabetic test strips to a diabetic be a medical crime defies belief. It should make it clear to the reader that there are serious flaws in Medical Council processes.

Second

Dr Y is a GP and affiliated provider to Southern Cross. He has been removing benign skin lesions in order to profit.

I have two independent witnesses to this fact.

I wrote to Mr Connolly requesting advice as to how I should respond to this according to Medical Council edict under the auspice of “protecting the public from harms”

I did not respond to his reply which was logically incoherent in that it failed to address the umbrella. That being that the doctor concerned must be either incompetent in diagnoses or intentionally removing clinically benign lesions

Southern Cross (personal communication) are well aware of the “issue”.

This fact informs me that either the diagnostic competence of many doctors is in question or that they are aware that they are removing benign lesions.

This is Assault and it is Fraud.

The cost – unknowable – but large

Third

Dr Z is a generic orthopaedic surgeon doing the rounds of White Cross clinics recruiting patients for arthroscopic knee surgery and maybe a few shoulders.

I have read a large number of papers on the topic going back more than a decade.

It has been clear for years that ACL reconstructions have been overapplied.

I am well aware of the debate surrounding the issue, have read the NICE guidelines and reviewed numerous relevant papers on the matter.

It is clear that with the exception of the professional athlete (who is a paid employee or contractor) the majority suffer no harm from conservative treatment and if necessary delayed reconstruction.

Despite drawing this to the attention of the ACC , the ACC minister, the Medical Council and attempting to have a coherent e mail debate with Professor Hooper on the matter it is business as usual.

In the meantime we have patients waiting for urgent orthopaedic surgery while elective surgery takes precedence

No doctor with a shred of conscience could see this as being acceptable.

No doubt there are some logistical issues to do with operating theatres etc – but I do not accept that these cannot be sorted.

The cost of pointless knee surgery (briefly discussed with my brother – ex fund manager ACC 13 years and recent recipient of failed arthrosopic knee surgery) “way more than a 100 million”.

Fourth

The language used to validate bad medical practice and designed to invoke a sense of security in the patient wrt therapy

1. Evidence based medicine. (EBM)

Apparently prior to this we were all witch doctors and holistic homeopathic colour therapists acting from a flawed but well meaning information base.

For maybe 15 years we have all changed to Best practice based upon “Evidence”

It is clear that those who introduced the term and continue to use it have no idea as to the fact that the evidence base is flawed for many reasons

This will be immediately clear to any reader up to date with their MOPS and so no need to articulate the obvious – but I will do so upon request along with many instances of drug company fraud, evidence wrt the frequency of fraud in medical research and so on.

2. Best Practice

Upon the shifting sands of EBM is constructed the castle of “Best practice”. Never mind that the walls of the castle are regularly fractured by earthquakes of real evidence. It is business as usual for those that are rewarded for ignoring it.

RECOMMENDATIONS

1. That the vernacular – derived from modern management bureaucracies be abandoned – and replaced by the more appropriate terms of yore. We can reclaim “update”. It is the truth – it makes no false claims and it is appropriate. I disregard any literature that claims “best practice”

2. It is a matter of absolute urgency that the Medical Council be disbanded and replaced by a body of intellectuals drawn from a variety of disciplines. A single intelligent layperson may have some place on such a body. Ideas for the composition of such a body could drawn from the USTPF , Cochrane or NICE. The medical profession is manifestly incapable of policing its own.

The Medical Profession is flawed at many levels

In the airline industry safety measures were implemented decades ago addressing aircrew interpersonal dynamics as it had become clear that these were a factor in accidents

The difference of course between an airplane and a medical/surgical team being that everyone dies on the airplane

Maybe if the same thing happened in medicine we would see a rapid shift in the toxic culture that is al to often to be found in operating theatres and between doctors sharing management of patients.

In 2016 a senior Australian surgeon commented on the adverse effect on patients as a consequence of bad behaviour of the surgeon and his/her effects on the team. It is an ongoing indictment upon the educators and leaders in our profession that toxic personalities are permitted to enter the profession, and once established create mayhem, disability and death.

In 2016 a Professor of Orthopaedics Ian Harris wrote a book “Surgery as placebo”

In this he refers to the sham arthroscopic surgery trial, and the lack of evidence for many spinal fusions and shoulder surgeries.

This essay has gone beyond the scope of MOPS.

It needed to – I hope it results in some change in culture in a profession which is sinecured and regularly abuses the trust that the public place in it.

Yours faithfully

[redacted]

Antonia O'leary

From: Ralph Chen-Green <ralphlcg@mac.com>
Sent: Tuesday, 21 March 2017 8:52 p.m.
To: sharon@nzma.org.nz; policy@rnzcgp.org.nz; Strategic Consultation
Cc: Ralph Chen-Green
Subject: FROM BMJ: Food for thought from the UK re Revalidation of older GPs - could Dr Sleath's scenario of GP exodus happen here?

http://blogs.bmj.com/bmj/2017/03/14/jonathan-sleath-why-revalidation-for-older-doctors-needs-to-change/?utm_source=marketing_email&utm_medium=Email&utm_campaign=WNOL%20&utm_content=blogs_2_150317&utm_term=

Jonathan Sleath: Why revalidation for older doctors needs to change

March 14, 2017

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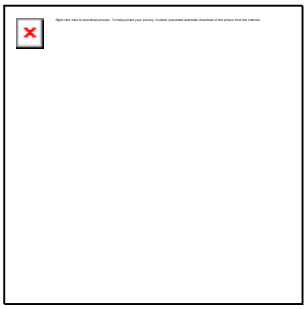

In January 2017, Keith Pearson, chair of the GMC's own Revalidation Advisory Board, delivered a review into the future of revalidation. For many of us, anxious for some crumbs of reassurance that this burdensome ritual would be reformed, this was a deeply depressing document. There are over 50 responses on the GMC website, almost unanimous in their view that this is a futile and bureaucratic process that is having a negative impact on patient care. In fact, apart from those employed by the appraisal and revalidation industry, it is very difficult to find a doctor who will claim that this is a worthwhile activity.

Nowhere is this felt more than amongst my own generation: doctors in their 50s who have submitted to the yoke of many years of appraisal and who have already undergone one revalidation. Every year the endless ritual of classifying, documenting, and submitting reflective documentation about the way we keep up to date seems to become increasingly tiresome. Many of us are growing weary of the process, and looking forward to the day when we no longer have to record our efforts at self-improvement. None of my patients has ever shown the slightest interest in the appraisal process.

In the BMA quarterly survey Q4 2015, nearly 50% of doctors were considering early retirement, with GPs being the most likely. In a study in 2016, over a quarter of such doctors gave appraisal and revalidation as an important factor in their decision. In the face of a GP workforce crisis, a report by the parliamentary Public Accounts Committee in 2016 urged NHS England to set out

how they plan to reduce the number of GPs leaving the profession early. Yet nobody seems to be listening.

None of the GMC's responses to the comments left on their website answer the concerns. When I wrote a letter in *The BMJ* about this matter. I had many replies in support, often describing battles with the GMC who seemed completely unsympathetic. I wrote to the minister for primary care suggesting that GP retention could be improved if the appraisal and revalidation requirements for older doctors could be relaxed, but merely had a response directing me back to the GMC.

The GMC's regulations state that to hold a licence to practice all doctors are required to be revalidated every five years. The annual appraisal requirements are set by the RCGP. Currently there is no mechanism to relax the appraisal process for experienced doctors wishing to continue to practice part time after retiring from full time work. This is just the time when it becomes more difficult to collect all the evidence required because of the reduced clinical contact.

It could be claimed that the GMC has a duty to protect the public by ensuring that all practising doctors meet the same high standards, no matter how little they are working. I think that the chance of anyone posing a danger to patients who has already successfully completed a revalidation cycle is negligible. I would argue that both the GMC and the RCGP have a duty to protect the public by doing what they can to maintain an adequate clinical workforce. This includes ensuring that by their actions they do not encourage the loss of capable and skilled doctors. They are manifestly failing in this duty, and together with NHS England and Health Education England need to come up with a solution quickly to avoid a continued ebbing away of experienced older doctors from clinical activity.

Jonathan Sleath is a general practitioner at Kingstone, Herefordshire, and is a member of the RCGP overdiagnosis group.

Competing interest: I intend to retire shortly from partnership but wish to continue to work part time.

Antonia O'leary

From: Richard Selkon <richard@sakiwi.co.nz>
Sent: Friday, 3 March 2017 2:45 p.m.
To: Strategic Consultation
Cc: 'policy@rnzcgp.org.nz'
Subject: Submission in respect of Recertification Proposals

Question 1:

Multisource Feedback -if this is proposed to include staff employed by a principle clinician such as administrative/reception/junior medical/nursing staff it is subject to bias as a result of practice hierarchy and of no substantive value. In addition, by what criteria are the aforementioned colleagues qualified to make such an assessment?. I would submit that the existing process of regular patient feedback surveys would likely provide more valuable information with less bias, and as such the change seems unwarranted.

Feedback from Peers External to a Doctors Usual Practice in my view is of extremely doubtful value as the reviewer would have no insight into the practice or the doctor they were reviewing, and as a result it will almost certainly result in a "simple chat with no substantive benefit" as has already been recognized in the Council notes by the statement "The minimum each year is a structured conversation" and is therefore an unwarranted waste of valuable time.

The proposal that Performance & Outcome Data should be used to inform the PDP is fraught with self-selection bias and opportunity for manipulation. It would in all likelihood be an extremely difficult process to implement in certain vocational scopes such as General Practice, compared with for example, a surgical specialty where there are clearer outcomes that can be measured. I am not at all convinced that this has a reasonable chance of success in General Practice or is the best idea going forward as the more "checkbox compliance tasks" that are imposed may well serve to distract doctors from useful self-learning & attendance at Continuing Professional Development talks or meetings. Council needs to consider realistically the nature of General Practice, the breakdown of the most common reason for medical consultations and it should become clear that performance & outcome data have an extremely limited role.

Question 2:

I agree with this proposal for the Professional Development Plan which is part of the current CPD requirement, only I disagree as stated above, with the Councils proposal that "Performance & Outcome Data should be used to inform the PDP" as I do not believe this is easily applicable to General Practice and other non-surgical specialties.

"Completion of CPD activities to address the PDP". This will introduce selection bias because there is very limited choice of CPD activities so the PDP's will be selected to fit the available CPD activities on offer. Mandatory linking of CPD activities to the PDP may well be counter-productive here.

Question 6:

I am concerned about the proposal in section C, viz: the "Career management planning for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement". This smacks of ageism and may potentially even breach the Bill of Rights Act. Who would the older doctor discuss this with and what is the medicolegal obligation of that doctor and how would they make any kind of objective assessment ? My own father was still working as a doctor in the UK and published his last paper in a world ranked medical journal at the age of 79. Older doctors make an invaluable contribution to the New Zealand Medical workforce, which has struggled in many specialties and locations to provide enough qualified staff. I don't believe Council can mandate changes according to age at all.

Question 8:

I believe that Council is trying to fix a system that's not broken, much like the recent policy on doctors treating themselves, family or friends, as acknowledged by Council in the statement "Doctors working in New Zealand are respected for the high standard of care they provide and are one of the most trusted groups in New Zealand. I have no doubt that Council will use its delegated regulatory authority to push through these changes irrespective of the feedback as there seems to be an agenda in Council that changes must eventuate at all costs. Unfortunately most doctors are far too busy trying to serve their patients and communities and do not have sufficient time or energy to participate and influence the outcome. It is my view that Council is attempting to micro-manage the professions and going beyond its statutory role of governance, this proposal regarding recertification should be withdrawn and left entirely up to the various Colleges to determine recertification processes as they see fit.

Question 9:

The major barriers to the proposals being successful are those that have been highlighted as unwarranted, unworkable, prone to selection bias and will simply become a tick-box compliance process of little actual value.

By making it far more onerous to comply it is likely that other adverse outcomes will eventuate. In the field of Primary Care, there are quite a number of us that hold Vocational Registration in two fields i.e.: General Practice and Urgent Care. As it stands, it is already extremely difficult to comply with the recertification requirements of both Colleges. In our discussions several of my colleagues and myself included, anticipate that because of the additional compliance burden we would need to resign from one of the Colleges and reduce our Vocational Registration to one field only. This will definitely result in a loss of skill and of doctors working in certain fields.

Dr Richard Selkon
Managing Director
Westgate Medical Centre
Home Email: richard@sakiwi.co.nz
www.wgmc.co.nz

Westgate MEDICAL CENTRE
Desire for Excellence, Passion for Care

Antonia O'leary

From: Bruce King <Bruce.King@nmhs.govt.nz>
Sent: Friday, 27 January 2017 12:30 p.m.
To: Strategic Consultation
Subject: Response - DHB focus

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

I do think this is an troublesome requirement – at least in its capacity in infer competence and quality of an individual. I believe that there is no ability for the Colleges to impact or influence this any more than MCNZ statement / directive, as the data collection and presentation is within the DHB environment.
I suspect the colleges will restate the position but refocus the emphasis for achievement back to the Doctor (who will then need to rely in the DHB data).

Performance = activity measures are everywhere in DHB data and at service or dept/hospital service level reported nationally. At an individual level they are also available but interpretation wrt Competence or Quality is at best tangential.
Outcome measures are Spartan in DHB data except Mortality & readmission neither of which link closely to Competence or Quality of an individuals practice. Emphasis on outcome measures for individual development may arise for patient satisfaction but the data set will be very small for any individual.

A capacity for individuals to refer to Departmental analyses to which they contribute would potentially improve both accurate compliance and impact on the issues at focus through the engagement within a Department in activity and available outcome measures. A step back from the intense focus on an individual makes sense.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

An annual cycle for PDP is a very short time especially for Generalists (usually with specialty interests). While annual review may be reasonable, a longer time frame for completion of the PDP "cycle" of activity reflection and review is prob more appropriate.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Most colleges have defined curricula for training designed to prepare a trainee for specialist practice but there-after the details of an individuals practice is hugely variable from a Generalist to a tertiary super sub specialist. The capacity of a central body to reasonably address this situation is unreasonable and inappropriate. It would be opportune to revise the responsibility back to the individual supported by head of Dept CMO and Clinical Governance systems within the employing DHB to agree to on scope of clinical delivery AND the PDP to reasonably maintain that practice. The notion of a Workplan and annual review of scope and delivery has gained traction progressively and this seems a natural extension of this.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

While an option, this is not problematic BUT could become a problem should it evolve to a compulsion simply due to the capacity to deliver PRP to all clinicians.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Again this crosses between Colleges who should be able to provide supports and the DHB who should be responsible for facilitating supports – this boundary between Professional college activity and employer responsibility needs to be clarified within the entire document.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No – competence and quality are not a function of the date of birth.
There may be a role for MCNZ intervention for concerns although I think the current MCNZ system is n place for this. The function of the accreditation process to is create an environment where indivuals and there colleagues and employers can identify concerns early and work together to address them.

No other commentary on remaining questions not already expressed.
Regards
bbk

Bruce King
Nelson Marlborough District Health Board
mailto:bruce.king@nmhs.govt.nz

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ✔ Group ☐ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ✔ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ✔ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
A good thing but the problem will be collecting good quality outcome data. How does one assess the performance of a general physician or geriatrician? I am not aware of any performance or outcome measures for these specialties. How would medical colleges assist doctors in this respect? The appraisal or APR will likely be done by the clinical director or medical head. The colleges' role will be to ensure these individuals are adequately trained in consultant appraisal.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

A good thing. They will need guidance from the appraiser as to how to develop a PDP

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

No comment.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Will the colleges cope with the potential demand?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

It depends what you mean by support. Individualised support from a college rep – again demand may stretch this service, or by providing general support by way of courses, workshops or seminars?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I don't think Council should mandate this because different doctors will have different needs/capabilities. Difficult to specify an age – some 65 year old doctors perform at a high level and some 55 year old doctors show signs of fatigue/burnout. Should be individualised, but always discussed at annual appraisal.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

What data will be collected? How will colleges measure the effectiveness of a recertification programme?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Overall a good thing.

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Doctor apathy. Training in appraisal. Collection of high quality performance and outcome measures.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
I don't think so. 5 years is more realistic.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ■ Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No ■ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ■ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
How does one obtain performance and outcome data? How does one organize external peer review? What is reviewed?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

It is essential that the depth and scope of what a PDP is be very well defined. Examples must be provided which are relevant to different specialities and sub specialities.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Is the knowledge requirement at both the speciality and sub speciality level? It would be quite simple to create a meaningless and unusable list of everything.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

This would otherwise be impossible to organize.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

What's the implication in the statement about age? *"…as doctors age?"* Is this just straightforward age discrimination? Is this a suggestion of increased vigilance or requirements on older doctors, like mandated driving exams at advanced certain ages? I would ask; Should Council mandate certain activities for doctors just beginning their careers who have limited practical experience?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Time. Money.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

No. I think three years of debate and planning before a decision is made would be appropriate.

I assume that the College is aware of what is transpiring in the US. The recertification requirements in Internal Medicine have been made so onerous in both cost, time, inconvenience and seeming lack of relevance, that a major professional and political backlash has occurred with thousands of doctors abandoning the preeminent Internal medicine medical college and forming a new one in order to establish what they consider more reasonable, feasible, and meaningful recertification programs. Will the Royal Colleges happily take on this risk for their organization?

Antonia O'leary

From: Avinesh Shankar <avi8024@gmail.com>
Sent: Wednesday, 25 January 2017 1:18 p.m.
To: Strategic Consultation
Subject: Vocational registration recertification consultations

I would encourage that these changes be done in consultation through relevant colleges (RACP in my case) and be worked through by looking (and improving) at existing models.

Regards,
Avinesh

Antonia O'leary

From: David Silverman <rotoruaadultmedicine@gmail.com>
Sent: Wednesday, 25 January 2017 3:35 p.m.
To: Strategic Consultation
Subject: Recertification feedback for vocationally registered physicians

The Council needs to recognise that vocationally registered physicians work in a variety of settings. The proposed changes seem to be most easily complied with by DHB-employed physicians and those in an organised private practice. I left full-time employment at a DHB a year ago and have since been doing locum hospital based work as a physician on a part-time basis. The amount of time I work is still in flux but it's probably going to settle at about 40%. I have worked at two different hospitals in NZ and two in Australia. The competence of all physicians, regardless of their practice setting needs to be assured. However some components of the requirements such as practice review, peer review, audit are more difficult for those of us who work as locums. It would be helpful if this were recognised by the College and steps taken to insure competence in ways that are in keeping with a career as a locum, are meaningful, and can be met.

Thanks,

David Silverman
MCNZ 46420

Antonia O'leary

From: Hans en Nienke Itjeshorst - Engel <hans@itjeshorst.nl>
Sent: Wednesday, 25 January 2017 10:11 p.m.
To: Strategic Consultation
Subject: RE: Consultation on recertification requirements for vocationally registered doctors

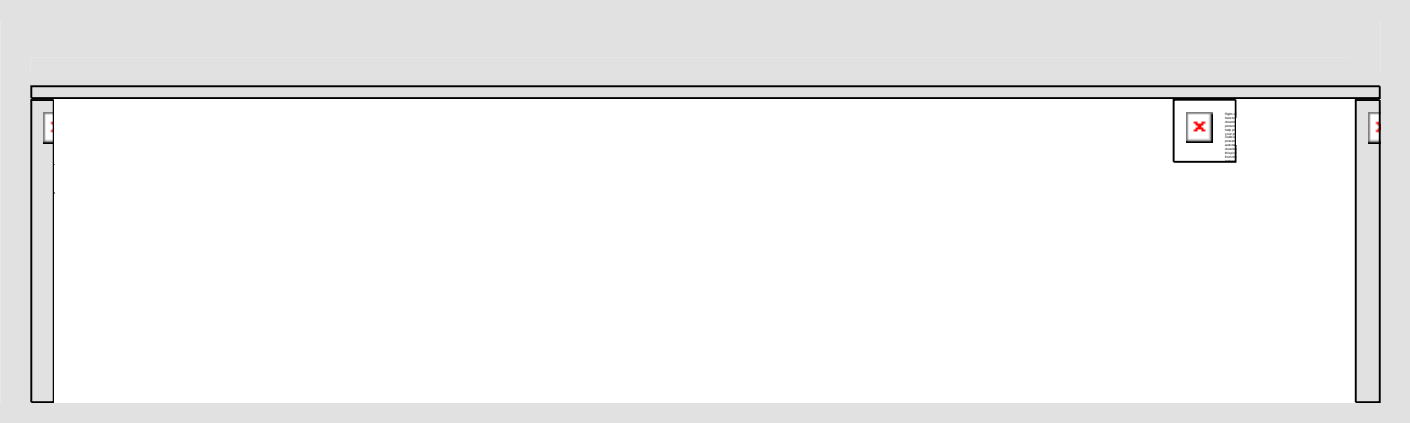
Dear colleagues,

Thanks for the invitation. If it was my choice I'd store these plans in the fridge and start focussing on improving the patient files first. Most patient files in New Zealand are incomplete. Medical history is often missing and littered with DHB and PHO requirements. A lot of GP notes are missing structure and are not read coded, making them as useful as a lose page in the back of an old book. In fact, MedTech, the most used computer program, doesn't even 'force' the GP to make a '(working) diagnosis' during a consultation. Apparently this is all not a problem during recertification visits. This is not the time for new recertification requirements in my view, let's first focus on the old ones and improve the outcomes.

Kind regards,

Hans Itjeshorst

From: MCNZ - Vocational Recertification Consultation [mailto:mcnz@mcnz.org.nz]
Sent: Wednesday, January 25, 2017 12:28 PM
To: hans@itjeshorst.nl
Subject: Consultation on recertification requirements for vocationally registered doctors



25 January 2017

Dear Colleague,

Consultation on recertification requirements for vocationally registered doctors

The Medical Council of New Zealand (Council) is reviewing the current recertification requirements for vocationally registered doctors and proposing new requirements and standards for medical college accreditation.

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors.

You can view and download the consultation paper and feedback form on Council's website at:

https://www.mcnz.org.nz/news-and-publications/consultations/consultation-on-strengthening-recertification-for-vocationally-registered-doctors/

Feedback on the consultation can be emailed to recertificationconsultation@mcnz.org.nz.

The deadline for submissions is **5pm Friday 10 March 2017**.

Yours sincerely

Mr Andrew Connolly
Chairman
Medical Council of New Zealand

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Antonia O'leary

From: Bruce Adlam (ADHB) <BAdlam@adhb.govt.nz>
Sent: Monday, 6 March 2017 11:29 a.m.
To: Strategic Consultation
Subject: Bruce Adlam - Final MCNZ Consulation feedback

I enclose my feedback on the proposed recertification consultation.

1. There is no indication as to who has written the document or who made up the group of people were involved in doing so. NZ is a small country and there are people we would trust in such an important set of changes and some we might have more concerns about. I have requested who was involved in this but although I received a reply to my other concerns I did not receive a reply to this so I am still left with a trust issue with regards to this proposed plan.
2. NZ practitioners aim to practice evidence-based medicine. NZMC should be no exception. I note many of the references included are not particularly current. I requested the literature review but this request was denied so I can only assume one was not done. This means I am left with a confidence problem with MCNZ to be proposing these changes. Many of us doubt the validity of patient feedback questionnaires and the proven value of the external peer review process is not presented here. I note Steve Lillis's paper and have read it. I acknowledge the work that has gone into it. I'm not in a position to judge whether he has a conflict of interest but I do note the tone is that of an opinion piece supported by selected studies. I note it was an invited article. I'm not sure what that means in terms of face validity.
3. The age concerns of the Medical Council have not been well presented here. I understand from a work colleague who has spoken with Andrew Conolly that the MCNZ receives more complaints from the patients of older doctors. If that's so then we need the proof around this. Older doctors have older patients, older patients have generally more complex problems, and communicating these complexities can be difficult. We would expect more complaints coming out of this group of patients so has the MCNZ matched practice age-sex registers when drawing this conclusion. Some colleges have support for their ageing members. What are the shortcomings of these programmes?

4. We have sought a legal opinion on the age question from our ADHB lawyer and I enclose it here

   <u>Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors' age? If so, what activities and what age should apply?</u>

   Response: any action based on age alone is frankly discriminatory and goes against the philosophy of any continuous improvement programme that purports to use an evidence-based assessment of training and development needs. It is also distressingly vague – what is 'career management planning' and why would those of a certain age require it in particular? Any specific age-related concerns need to be stated upfront and if these concerns, rather than a certain age per se, are present then the discussion can proceed regarding how best they should be addressed and indeed whether it is best to do so via a recertification programme.

   The MCNZ will be aware of the law as it relates to discrimination on the basis of age: the New Zealand Bill of Rights Act 1990, section 19 states that everyone has the right to freedom from discrimination. The grounds for discrimination are laid out in the Human Rights Act 1993, section 21(1)(i), which states that age is a prohibited ground for discrimination.

Furthermore if older doctors were faced with additional or differing training requirements that may be less favourable or more burdensome than that faced by other doctors, our legal advisors suggest that a breach of section 40(b) relating to vocational training bodies would be applicable:

'Vocational training bodies – it shall be unlawful for any organisation or association which has as its function or one of its principal functions the provision of training, or facilities or opportunities for training (including facilities or opportunities by way of financial grants), that would help fit a person for any employment, or any person acting or purporting to act on behalf of any such organisation or association,-

(b) to provide training, or facilities or opportunities for training, on less favourable terms and conditions than would otherwise be made available; -
by reason of any of the prohibited grounds for discrimination.'

In addition, if the new recertification requirements were particularly burdensome for older doctors such that they caused older doctors into leaving the profession, our legal advisors would consider this to be in breach of section 22 of the Human Rights Act 1993, which states:

'Where an applicant for employment or an employee is qualified for work of any description, it shall be unlawful for an employer, or any person acting or purporting to act on behalf of the employer,-

(d) to retire the employee, or to require or cause the employee to retire or resign'

A key point to make in law with regard to discrimination on the basis of age is that any proposal to do so would need to be supported by robust evidence that using age as a basis to select doctors for training is valid. However my colleagues and our legal advisors suggest that there is no such evidence that would meet the legislative standard of proof.

5. Performance and outcome data applies to some of the branches of medicine but not all. Some outcomes are counter-factual especially in primary care and public health medicine. It's not spelled out in this document how you intend to guide the colleges in performance and outcomes where the outcome or performance is the absence of disease in a matched population.

Steve Lillis reply to me on 20/2/2017 which I enclose here goes some way to be reassuring.

Thank you for your response. I do note your comment where you imply that the purpose is to find 5% of doctors at the cost of putting 95% through unnecessary hoops. I assure you that this is not the purpose of the initiative. I would draw your attention to the vision as stated in the document:

Vision
Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support continuing improvement in performance.

Supporting continuous improvement in performance is the objective. It is the Colleges, not the MCNZ, who will be developing the recertification programmes and the Colleges who will be deciding on quality indicators. The Colleges will also be using the vision statement above in the design of such programmes. Similarly, the principles in the document clearly state that the activities are formative in nature.

Quality recertification activities are:
- Evidence-based.
- Formative in nature.
- Informed by relevant data.
- Based in the doctor's actual work and workplace setting.

- Profession-led.
- Informed by public input and referenced to the *Code of Consumers' Rights*.
- Supported by employers.

I hope that you find this reassuring

I explained that my concerns were that 95% of doctors are put through additional recertification hurdles for the 1% ~ 5 % who come to the attention of MCNZ or Health and Disability Commissioner. It is already difficult to maintain re-accreditation especially when you might be practicing in two different fields e .g GP and Public Health. I'm assured this is not the case but it is a perception held by a good number of my work colleagues and I suspect we are not alone.

In summary I have a trust issue, a confidence issue and clearly a perception issue with the proposed changes notwithstanding the additional requirements based on age which may be unlawful.

Yours sincerely

Dr Bruce Adlam

Medical Officer Communicable Diseases
Population Protection Group

Auckland Regional Public Health Service
☎ 09 623 4600 | ext 27214 | 021 223 8358
Fax: 09 630 7431 | ✉ badlam@adhb.govt.nz
Website: www.arphs.govt.nz

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Consultation on strengthening recertification for vocationally registered doctors

Feedback

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Doctors' performance and outcome data are hard to come by and often unreliable (see *Scholle et al, Benchmarking Physician Performance: Composite measures; Am J Manag Care, 2008*). Data collection is time consuming, and given the lack of evidence that tailored PDP's based on (perhaps unreliable) performance and outcome data will actually improve patients' outcome, I believe the resources are better used in actual patients' care.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Participating in Professional Development is already part of the requirement for registration with the MCNZ and the colleges.
Formulating a PDP one year in advance will most likely result in the use of meaningless phrases such as "will attend conference", "participate in peer

reviews", it is also unclear how and by whom PDP will be policed and if there are any sanction should a PDP change over the course of the year. Sometimes opportunities like conferences or courses arise with short notice and plans may change. I do not believe there is any evidence to suggest that PDP's improve clinical practice above simply participating in a mandated number of activities over a certain time period.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence, cultural competence, and the Code of Health and Disability Services Consumer's Rights.

Question 3:
What is your view of medical colleges defining knowledge requirements? It is very difficult to define "knowledge requirements" in Medicine as some of the knowledge may have a very short half-life. Incorporating them into their recertification programmes would be a very onerous task requiring additional resources.

The "standards of medical practice" already exist and would be unlikely to be in conflict with any "knowledge requirement" as mandated by the colleges.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The term R("regular")PR appears to be at odds with the idea that doctors can undertake it voluntarily. Colleges already have assessment tools such as the Vocational Practice Assessment (VPA), which is being used to assess overseas trained doctors. Colleges probably should have tools for Practice Reviews (not necessarily regular) which doctors may choose to undertake, but also robust tools for assessment and review of "underperforming" doctors.

Most of these tools are probably best be used depending on circumstances and not spread out over the whole workforce.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I believe additional support should not only be provided by the colleges, but also the Council.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I don't think every doctor working in New Zealand is in need of "career management planning". Council may offer certain activities if doctors want career management planning, but it should not be mandated.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I think it is a good idea to collect data and analyse it. In evidence based medicine this is the first step to assess a problem. I strongly feel that *before*

proposals such is this are being made, data should be analysed first, problems identified and then solutions discussed. Unfortunately this proposal looks to me like offering a solution first without the knowledge of problems.

General Questions:

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Doctors are already overwhelmed by increasing requirements for recertification and supervision of RMO's. Recent changes for recertification include mandatory audits. I believe this has not resulted in any improvement of clinical practice overall or in individuals. To my knowledge the implementation of audits has not been analysed to verify their usefulness. It appears to me that there is a tendency to adding on new requirements rather than challenging the existing ones.
I believe most doctors will see the implementation as a nuisance resulting in more work without having a clear benefit. Most will choose to "play the system", examples I have provided in answer to Q2.
Little emphasis has been put on the cost (and perhaps the cost/benefit ratio) of the changes, let alone the available resources. Independent practice reviews such as the proposed RPR are very onerous.
As an overseas trained physician I underwent a VPA. To make the assessment as fair and robust as possible it required two physicians from another DHB for an entire day. This did not include preparation or travel time, it involved a number of people for time consuming tasks such as getting clinic notes, filling in feedback forms, etc. It also came with a substantial cost of several thousand dollars (now almost $10,000 according to MCNZ, no doubt to cover the expenses). It is difficult to imagine how such a system could be implemented across the board without seriously affecting patients' care due to absent doctors and additional costs for the DHB's.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes. After three years it needs to be thoroughly analysed and reviewed.

General Comments:
I would like to thank you for the opportunity to provide feedback to your proposed changes. As you have noticed I have not only concerns about the need for those changes, but also about available resources. I am also unsure as to what problem the Council actually wants to solve. The changes proposed in the document available are well-intended but – as far as I can tell – mainly based on theoretical models. It is rather telling that a proposal for substantial changes makes no reference to the deficiencies of the existing system and only quotes nine sources, most of which older than ten years and of doubtful relevance.

I am very much in favour of evidence based changes, particularly if they have shown to improve patients' outcome.
However, if evidence is lacking and changes are merely considered to be a good idea worth exploring, please let us doctors have a vote on this. Clearly we are the ones whose support you seek and changes are supposed to serve our interests as well.

Kind regards

Dr. med. Bernd Kraus
General Physician, FRACP
Whanganui DHB

10 March 2015

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
1. Performance and outcome data are hugely dependent on the environment and the teams specialists work within. This is particularly true for non-proceduralist Physicians like General Medical, Infectious Disease, Geriatricians, etc. The relevant subspecialty committees and scientific societies will need to be responsible for developing appropriate performance and outcome data, which are meaningful and specialty-specific. 2. Multisource feedback (AKA "satisfaction surveys") are a very blunt tool and bear very little significance in my experience. They should not be a mandatory requirement to identify professional development needs. **3.** External peer review is a very labour-intensive and costly exercise. It means having specialists in each and every subspecialty area criss-crossing the Country all the time to provide external peer review to each other. The costs in lost days of work to be compensated, travel, accommodation,

and board expenses to be reimbursed, would be phenomenal. Who would pay for them? The employers?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

We (physicians) have already PDPs as an optional component of the RACP MyCPD plan. Not a big issue.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The RACP is a big College including numerous and diverse sub-specialties in the field of Internal Medicine. It makes very little sense for the RACP to define the knowledge requirements of such a diverse Specialist membership. The specialty-specific subcommittees and scientific societies (e.g., [redacted], ASID, ASHM, NZSHS, etc.) are in a much better position to define the knowledge requirements for their members.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

See above my concerns re the external peer review. It would be a logistic and financial nightmare. I cannot see it happening on a voluntary basis and it would be simply unfeasible on a mandatory basis.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

professional development needs?

Any such support will need to be confidential, peer-lead, and not follow a punitive approach.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

1. Age > 65
2. Ageing doctors area valuable resource, not an liability as this "career management planning" seems to suggest. As long as an ageing doctor is looking after themselves (having a GP, taking leave as appropriate, etc.), I cannot see any reason why they should be discriminated against.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I understand the RACP is already doing this.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I do not welcome this proposal. The Colleges are the most appropriate forum for these activities with regards to Fellows and Trainees.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Yes – feasibility and costs as outlined above. The Council should just leave this matter to the Colleges.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

No, it is not appropriate nor practical. At least 5 years will be needed, if we are at all going to implement it.

Antonia O'leary

From: Chris Kenedi
Sent: Wednesday, 25 January 2017 2:37 p.m.
To: Strategic Consultation
Cc: Chris Kenedi
Subject: Recertification

These proposed changes seemed to be based on a series of papers from the 1990s and mid-2000s when a similar set of initiatives were put in places in the United States.
In the eleven years since the last paper was published, there has been a rollback of these initiatives as they were found to be time-intensive, expensive and without any clear end-benefit to the clinician or the patient.

Every time an organization like the MCNZ adds additional requirements the costs get passed on to the doctor and in many cases to the DHB. This erodes a limited pool of resources whereby the marginal (or in some of the recommendations, negative benefits) are not balanced against the cost – doctor's costs go up and the DHB reduces physician FTE to adjust to a fixed budget. In a society where the population is increasing this results in doctors having more clinical work and seeing more patients and having more onerous recertification requirements to meet a procedural, administrative need to show relevance.

I also recertify through the North Carolina Medical Board (regulator equivalent to the MCNZ) and the American Board of Internal Medicine and the American Board of Psychiatry and Neurology. Both those boards (which are equivalent to vocational registration in NZ) have recently removed or applied to remove many of the requirements you are now proposing. Why? Because they have data that there is no end benefit for the cost in money and time to the clinicians. Neither group is thought of as responsive to clinicians, but they still saw that these measures were inappropriate.

Why is the MCNZ using a series of JAMA articles (Several of which came from a single consensus project), that are 11+ years out of date to now reinvent a structure that is being dis-established by the American organizations these articles were aimed at?

Using the colleges to facilitate these requirements adds an exponential cost as the Colleges are non-competitive and have no incentive for cost-efficiencies. They are bloated, administrative heavy organizations that clinicians are forced to pay exorbitant amounts to be part of to do the job they have been trained for.

Fundamentally the goal of the MCNZ in maintaining high requirements for doctors is laudable and necessary as a framework for competency. But there has to be a realistic appraisal of the limitations and not just the strengths of this system. Human nature being what it is, the pressures of the work being what they are, the more elaborate the system, the more it is a house of cards designed to look good to the public. The best system would force doctors to engage in CME that parallels their clinical practice, which is the intention.

However the best intentions of the committee don't often end up practically deployed as envisioned. The layers of the college, the IT infrastructure and other factors often lead to clunky, rote projects that have little practical value or reflection.

Question 1. Per above. It will be expensive, clunky and onerous. It is not clear that it will actually lead to significant change or improvement. While the MCNZ is enamoured with PDPs there is no or conflicting recent data to support this.

Question 2. As Question 1. There must be some sense that the more time you demand that clinicians spend on this activity is coming out of their non-clinical time, which means less time for actual CME, teaching, research, and practice review.

Question 3. The Colleges systems are ponderous and non-competitive income streams. There is no one involved in this process to represent the coal-face clinician or the DHB who funds much of this.
However it is not clear that there is any alternative.

Question 4. It could be done very well if the model was lean and focused, similar to how the Ministry of Education offers practice review to early childhood centres.

Question 5. Colleges approaches to this are variable and depend on the individuals and resources employed.

Question 6. I'm unaware of the data for this.

Question 7. I'm guessing this will be expensive and shockingly will show how good a job the colleges are doing and the need to expand their programs….

Chris Kenedi, MD, MPH, FRACP, FACP
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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual X☐ Group ☐
[redacted]
Do you agree to your submission, or parts of your submission being published: No X
Do you agree to all or parts of your submission being published if it was anonymised: Yes X

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

This places a significant time burden on doctors who must audit outcome data which may not be readily available. Whilst targeting individual outcome data for audit may bring benefits it will inevitably drag attention away from "whole of system" audits as these don't produce individual outcome data. Both may be productive for doctors to undertake but there is an opportunity cost to this path which needs to be recognised.
It also encourages "chump audits" (which in my view are not discouraged currently) where audits are done to tick a box rather than provide any useful data. For example [redacted] I could request data on the length of stay of my patients with COPD (or any other common condition), compare it to others' LOS, and discuss with peers that my length of stay is (likely) similar to others with comparable patients. This takes almost no time or effort, and is very unlikely to generate useful insight, but ticks the box. There should be recognition of broader, whole-of-system audits as having value rather

than a simple requirement for individual patient outcome data.
Other than perhaps providing templates or suggestions for easy audits, I'm not sure how medical colleges could provide much assistance.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This is not unreasonable but again places a time burden.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I think this is a good idea.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I think this is a good idea, though I have not personally used this tool yet.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I am concerned that this places an onus on colleges to individually manage the careers and professional development of their fellows, who in reality need to be doing this for themselves, with guidance for those having difficulty being an appropriate college role.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I do not believe that age should be used to mandate differing requirements.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

No specific feedback.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

No
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
The real challenges are going to be the extra time required for practitioners and the support from employers which is required for this to be achieved.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Probably.

Antonia O'leary

From: Dr Naser Abdul-Ghaffar <naser@naserhome.com>
Sent: Thursday, 2 March 2017 2:13 p.m.
To: Strategic Consultation
Subject: recertification consultation submission

Dear Sir or Madam

Please find my submission hereunder.

Dr Naser Abdul-Ghaffar FRCP (Ireland)
Consultant Physician
Wairarapa Hospital
Vocational Scope: Internal Medicine
Registration Number: 22577

Guiding questions for submissions

Proposal: Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1: Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

I disagree. Unnecessary documentation and waste of time. Doctors with the collages has been doing good job for ages. I see the intervention of the medical council this way is not useful at all. Collages are doing this already. Regular quality assurance activities are already happening.

Proposal: Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2: Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

This does not need extra unnecessary documentation and should be the responsibility of the practitioner who should continue to practice competently.

Proposal: Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence3, cultural competence, and the Code of Health and Disability Services Consumer's Rights.

Question 3: What is your view of medical colleges defining knowledge requirements?

There are huge variations in the set of knowledge required depending upon the subspecialty interest of different practitioners. We are required to attend conferences, courses meetings etcetera. The set of knowledge needed for a general physician for example is different depending on the subspecialty interest of the physician, a general cardiologist is different from an intervention cardiologist which is different again from the electro-physiologist. It is up to the practitioner to keep himself up-to-date to practice competently. In New Zealand's Health system, many practitioners share the care of a given patient including GP, specialists, subspecialists and the patient gets admitted under different specialists on different occasions. Added to this the regular audit meeting and peer review. In my opinion practitioners should be responsible for the set of knowledge they require to practice competently. Colleges always give appropriate support as needed.

Proposal: Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4: Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

3 Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

This is already there on voluntary bases in RACP. I used it twice before. Having it obligatory will lead to huge waste of time and cost implication. It will not improve the patients' care or patients' outcome. It should remain voluntary.

Page 10 of 11

Proposal: Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5: Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I believe this is available in the form of conferences and courses provided by the colleges.

Question 6: Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I believe this is not required. Any age driven activity is not justifiable. All doctors should take part in peer review meetings and audit meetings. GPs practicing in isolation should take part in quality assurance activities. Hospital practice in general is a supportive environment for all practitioners regardless of the age.

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7: Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Not clear at all. The RACP supports quality assurance activity. I believe this apply to all other colleges.

General Questions:

Question 8: Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

Additional standards are not required.

Question 9: Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

This will complicate the process with no benefit at all as regards patient's safety or patients outcome.

Question 10: Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

I disagree with proposal. We cannot claim that practice in New Zealand is better than other countries like Australia and UK. The registration bodies in these countries leave the Recertification requirements up to the relevant colleges. The Medical Council in my opinion should make sure that the practitioner is compliant with his/her college requirement rather than interfering with the details which would be very different in different colleges. I believe that this move will complicate the process and I cannot see how it will improve the patients' outcome.

Dr Naser Abdul-Ghaffar FRCP (Ireland)
Consultant Physician
Wairarapa Hospital

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Senior Project Manager
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Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **Name: Julian Crane** **Position/title: Research Professor (medicine)** **Organisation: Department of Medicine, University of Otago, Wellington** **Do you agree to your submission, or parts of your submission being published**: Yes **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
In essence this sounds sensible. What surprises me is that the evidence presented is so thin with references that seem outdated, the oldest is 22 years old, reference (iv) refers to cost effectiveness which seems irrelevant in the context of this proposal and none of the work involves the NZ or Australian situation. There have been large changes in this landscape in Australia and the UK and a growing literature analysing the issues of certification and complaints which I would have thought would be useful to consider here. **My questions would be:** **1. How do we know that the current CME arrangements in NZ don't work? What is the evidence? If it exists why isn't it being shared with medical profession via the council**

2. **How do we know that the new CME arrangements will be any better? What preliminary evidence is there and will evidence be collected to make valid comparisons between the previous and new approach?**
3. **What measures or studies will there be to try and answer these questions. If none, we will never know which seems to me inappropriate when we try wherever possible to base our practice on evidence.**
4. **The new proposal from vocationally registered doctors have been used for general registered doctors – what feedback, audit, research is there on this?**

It is not clear what discussions or preparations have taken place with the colleges but on the face of it, it seems a large task to ask of the colleges and they of course will need to hold detailed discussions and feedback with their membership before moving forward.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Again regular practice audits appear to be sensible. This and the PDP, RPR and MSF are already a part of the general scope of practice for doctors in training. Presumably there is some evaluations of this that can inform its extension to vocational scope?

The proposed elements of the PDP ie 1a(ii and iii) (notwithstanding comments above) would seem to have the potential to suffer a number of potential biases from colleagues and patients in terms of leniency bias or malevolence bias and of course selection bias . Is there any evidence that these are more useful than the current recertification programme. Is the 'minimum' of a structured conversation with a colleague likely to be very useful – is there any evidence that it is useful?

The colleges already undertake training requirements and set examinations for those wishing to enter vocational practice and the medical council uses examination for many foreign trained doctors so it has always struck me that while as a profession we use examinations to assess the level at which we believe individuals are competent to practice or have reached a level of specialist expertise we are reluctant to use such techniques on ourselves for ongoing assessments. I am sure that recertification authorities everywhere and including the MCNZ have considered this in the past and one would foresee considerable push back from the profession, nevertheless such assessment could be very informative both broadly for the profession and individually to highlight areas of knowledge or practice weakness.

As a member of the public I would have more faith in some sort of unbiased more objective type of assessment than I would in the proposed suggestions here. In the end it seems inevitable that something more rigorous will be required if not imposed.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This should be possible but only in fairly broad dimension. I would imagine it would also take some time.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Again, there have been optional aspects to CME – is there an evaluation of these? One might imagine that the very doctors who have specific weak areas might not be the ones who choose to participate.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This is a good idea but unless there is some realistic unbiased ongoing assessment of a doctor's knowledge and practice through their career how would the colleges glean the needs of members. It seems unlikely (and indeed there is evidence) that practitioners are unlikely to clearly recognise their shortcomings themselves. Given the research regarding complaints against doctors, the evidence, at least from the US and Australia is that a very small minority generate a large proportion of them and it would seem that we need robust methods to identify and help such practitioners as early as possible, often during their undergraduate years. Again don't we need local research here and robust evidence?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

This is clearly a really important issue. There is evidence that chronological age is a rather blunt instrument for individual age related competence. More useful to actually collect data over time and observe the effects of chronological age on all the different types of practice, one would then be in a position to make suggestions or mandate activities accordingly – these could be individualised.

One issue that does not seem to be discussed is the time frame for these activities. They all seem to be annual – why? What is the evidence that they need to be this often in someone who is engaged regularly in clinical practice? Why not something more comprehensive less regularly?

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Some regular formal unbiased assessment should certainly be systematically collected and analysed over time. Furthermore, as data is built up and trends and associations found anonymised aggregate data could be made publically available as a further way to increase transparency and provide public assurance. The mandatory reporting of health practitioners in Australia is providing a valuable analytic resource to study aspects of competence and the reasons for complaints. Do we need something similar here?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

My concerns with these proposals are that they appear to be a relatively evidence free zone. No evidence has been presented to encourage me that proposed changes will offer any real improvement. It would seem that it is vital to think much more carefully about how evidence is collected and evaluated to ensure ongoing competence during a doctor's entire career. In my view the profession would do much better to build this properly and evidentially for the long term rather than tinkering with it at the margins with potentially biased interventions of unknown value.

Ultimately as the council recognises if we don't do it properly it will be mandated elsewhere.

It surprises me that we have not considered a closer alignment to the continuing proficiency requirements of commercial pilots. Why is this? Presumably because apart from the passengers there is a 2-400 million dollar plane to worry about aswell. In the commercial aviation environment there is an ongoing recognition that increasing responsibility is coupled with rising seniority and experience well after initial training and competence has been reached.

Ongoing medical education seems to be very poorly conducted, often placed in the hands of the pharmaceutical industry with or without medical society involvement. All too often the alignment between these societies and big pharma becomes blurred and appears mainly concerned with income genertaion. Many so called educational meetings are little more than advertisements. Is this really the best model?

Medical practice like everything else is changing rapidly with technological and therapeutic advances that have no proficiency oversight during a doctor's career. Do we not need to give this consideration also?

Many doctors in clinical practice operate in teams, where a variety of staff bring different elements to the diagnostic and therapeutic environment. Does there not need to be some mechanism(s) to assess how these are working ie the practitioner not just in isolation but how he or she operates in his or her team environment? Much of medical training still relies on the apprenticeship model. My own experience (and I am sure that of most others) was that as a trainee I collected skills and clinical' wisdom' from my senior colleagues and often in return provided a more aggressive or novel approach to clinical situations because as a trainee I was continually updating myself with a view to upcoming examinations. So here is a two way process that also may need to be considered in the mix of maintaining and upgrading knowledge.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

I do not know what the various colleges will think about these proposals and I assume that the council has had some detailed discussions with them already. A period of pilot studies and evaluation would seem to me to be useful

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

See 9 above. Far longer to introduce a robust fit for purpose, evidence based system for the long term.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☒ Group ☐ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☒ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☒ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Multisource feedback is a complex process, and requires the provision of forms (to be completed by those providing feedback). The collection and analysis of the feedback should also be separated from the doctor so that those providing it feel free to express themselves fully. This requires an infrastructure which I believe the MCNZ should provide, or at least clearly specify. My recall is that the RNZCGP does this well, and their process could be a useful model.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I imagine this is routine already.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Support this.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

My view is that this should be a requirement not voluntary. Perhaps every 3-5 years. Would be too onerous every year.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This runs the risk of being intrusive. It could be *offered* to doctors by the colleges. It would be a significant expansion of the role of colleges.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No. This implies that age is a determining factor. Is gender or race one?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Standard stuff.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

The RANZCP and some other colleges are transnational. Unilateral requirements from NZ may or may not be acceptable or funded. Is the MCNZ working with the AMC around standardisation?

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes

Strengthening recertification for vocationally registered doctors
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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
It is impratical and almost impossible for doctors in private practice to elicit regular multisource feedback and external peer review.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

That's reasonable and it is already the case, at least in my specialty.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The Medical Colleges should define the knowledge requirements. The Council should take advice from the Colleges and not the other way round.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

This should remain on a voluntary basis. The imposition of ever increasing requirements on individual doctors only divert precious clinical time into ever increasing bureaucratic demands and stress.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

That is a basic function of a medical college.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This is an expected role of medical colleges. That's why medical colleges exist.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Ever increasing regulations, other than related to the basic foundations of a profession, or trade has been shown not to work, or provide benefits in any setting. Over-regulation stiffles professional practice and only benefit bureaucrats.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The proposal is not practical. The statement that there is an issue is not sufficient evidence there is an issue. There is plenty of demands on doctors already. It is characteristic in any regulatory body to engage in ever increasing regulations in attempts to fix problems brought about by previous regulations. It is a vicious circle.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

There is no need for new recertification requirements.

Antonia O'leary

From: Ian Hosford <Ian.Hosford@hawkesbaydhb.govt.nz>
Sent: Wednesday, 25 January 2017 2:15 p.m.
To: Strategic Consultation
Subject: Feedback on 'strengthening recertification of vocationally registered doctors'

I have a number of concerns about this document:

- A convincing argument that there is a problem with our current recertification has not been presented. My College has very high CPD standards which meet the requirements of Australia and other developed countries. Implicit in this document is that they are not adequate – and if this process is put in place, there would need to be changes to what we currently do. The case to make major changes has not been made, in my opinion.
- Is there any evidence that the proposed process will be better than (or even as good as) existing CPD programs? The references are mostly over 10 years old and do not seem to be comparative – and most of the newer ones are not from mainstream journals. This document demands major changes – is there evidence that this process will produce better outcomes? The Council is demanding evidence based practice, after all.
- The changes will be more time consuming and costly. I have no doubt that the additional costs that the Colleges will have in setting this up and providing the 'support', practice visits etc. will be handed down to the doctors. That may not be a concern to the Council but it will be a concern to the doctors (and DHBs). This will also require more administration from practitioners and Colleges – this comes at a cost….which no doubt, will be carried by the doctors.
- Is there any evidence that this new process will be cost-effective compared to the existing processes? Will improved outcomes (if there are any) be worth the additional money spent to achieve them? There is only one reference on cost effectiveness – but that is not comparing systems. We need to be very careful how money is spent, particularly in our public health system.
- Managing ageing doctors is a concern to the Council and the profession. I think Council is overly optimistic in thinking that this can be managed in discussions between employers and doctors – or colleagues and doctors – or even in 'career plans'. Most managers do not have the skills to deal with this issue and leave it to colleagues 'to have a chat with him' – which means nothing much happens. Maybe you are hoping that this new process will deal with the issues – at the expense of burdening the rest of the profession with it. Maybe older doctors will just get fed up with this and stop – but you may lose some very good doctors along the way – who did not need to stop work but just got fed up with paperwork.
- Requiring older doctors to have regular practice reviews by a trained colleague either from College or Medical Council – in a structured way (perhaps a bit like the BPAC practice visits) – may be more effective and more specifically address the issue. Perhaps every 3 years after the age of 60, 2 years after 70 and annually after 80. Or even more – 2 years after 60, annually after 70. Again you would need to look at the cost effectiveness of this.

Ian Hosford
14755

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Karen Davis

To: Sasho Todorovski (WDHB)
Subject: RE: Consultation Feedback Form

From: Sasho Todorovski (WDHB) [mailto:Sasho.Todorovski@waitematadhb.govt.nz]
Sent: Wednesday, 8 February 2017 4:14 p.m.
To: Strategic Consultation
Subject: Consultation Feedback Form

Please, find my feedback enclosed.

Kind regards,
Dr Sasho Todorovski
MCNZ RN 31 771

Strengthening recertification for vocationally registered doctors

You are invited to provide feedback on Council's proposal to strengthen recertification requirem onally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐ **Name:** **Position/title:** **Organisation:** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.**

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

I think that doctors should be able to incorporate the performance and outcome data in their PDP. The support from colleagues should be optional.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Should have significant but probably not central role as the plan should be open for amendments/ updates. Drs might need to undertake activities that have not been outlined/ anticipated.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The knowledge requirements should be defined by the colleges, but should be placed in the context of the day to day work where the ability to implement the knowledge is what is important.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

It should remain as an option.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I agree with the considerations

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I do not think that the council should mandate the activities based on Drs' age unless there was evidence that age-related issues interfere with the Drs' performance.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The CQI depends not only on Drs' professional skills and capacities but also on the working and broader environment (resources, policies, expectations of the public etc…)

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

No I don't.

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
As in Q 7. I am talking from a psychiatrist's perspective. Dr's performance significantly depends on the working and broader environment. Minimizing the non-medical pathogenic factors (ie social issues) can significantly lessen the pressure that psychiatrists and GPs work within, and would enable them to perform better/ focus more on medical issues. The outcomes in psychiatry not that seldom are influenced by adverse social factors. This in turn can indicate lower performance. So the assessment of Dr's performance should take these confounding factors into account.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Probably.

Legal Disclaimer

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Strengthening recertification for vocationally registered doctors
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Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **X** Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
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It is good but not very practical as it involves lots of paperwork and will require additional non-clinical time and I am already very much concerned about the quality and quantity of our clinical time which is our prime responsibility towards our clients and our professional satisfaction and how its going to affect the justifiable distribution of our clinical and non clinical time.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I think it is reasonable to except from a professional and every doctor should be responsible to make individualized program even if part of an organization or in private practice.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I think it is very clear and understandable, and clearly helpful in maintaining standard and quality of professional conduct and practice which I totally agree.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Absolutely agree as it will help not only doctors working in public sector mainly, public + private sector equally and also for the doctors who work mostly in private sector.

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Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Absolutely necessary as already pointed above that it will benefit and cover the doctors who are mainly in private practice and particularly in solo private practice and the doctors with some kind of shortcomings due to their personal preferences or physical health or family/ domestic situations.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctor's age? If so, what activities and what age should apply?

This is a brilliant idea as doctor is only profession which doesn't have retirement and support with age will be helpful for keeping an aging doctor active and engaged in his professional growth even with or without certain limitations.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

That is absolutely necessary and it will give an overview of strengths and setbacks of certain plans and will support continuous quality improvement of a medical doctor and the team as whole.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I agree with council's proposal as collaborative approach will not only help individual or organization but the standard of care to our clients.

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Not what I think of at the moment but only issue which I can think of that a doctor's clinical duties towards the care of his/her clients should not suffer with too many non-clinical paperwork and lengthy audit processes.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Seems practical and appropriate as I perceived.

Strengthening recertification for vocationally registered doctors
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Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐ **Name: Adam Sims** **Position/title: Psychiatrist** **Organisation: CCDHB** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
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All these activities take considerable resources both for the doctor who is being certified and for other doctors who are in support of this process. In an already stretched health system additional regulations in the absence of clear evidence that they improve outcomes and health benefits for patients is questionable. Rather than all doctors having to go through what will likely amount to a hoop jumping exercise I would think targeted professional development for certain groups or individuals would be a better use of resource and therefore outcome. **Audit can have benefit but only if well planned, targeted and appropriate to the individuals doctors circumstances.** **In my opinion peer review provides a setting in which some of these goals could be accomplished without putting further barriers to accreditation. For example feedback from peers in peer review might be something to consider or a requirement that CPD is built into the peer review process (ie presenting**

to peers about CPD and getting feedback about this)
Currently colleges support peer review and I think they should continue to support the structure of peer review.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Individualised plans are helpful. At present I suspect they are done in retrospect. Building them into the peer review process might assist the process in getting completion intitially.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Colleges are really a group of professionals who practice in the same area. Thus they are the repository of the general consensus of knowledge about the area. They are also tasked with setting the standards of examination to enter the profession. I cannot see there are any other bodies that would have the same level of knowledge in the area. By default they must continue to define the standards required of the members.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The challenge of regular practice review are the time and resources available to provide it in a meaningful way. Stating regular practice review as a voluntary activity will mean it is unlikely to be widely adopted. While feedback is helpful for all doctors it needs to be balanced. My experience of doing external examinations through the college and getting feedback from many others at the time led me to filter and select what I considered to be appropriate and was dependent on my own opinions of the individual who provided the feedback.

There maybe some doctors who would benefit from this type of feedback more than others. I suspect they are also the people who would least like to enrol in this as a voluntary activity.

If greater feedback is seen as necessary my overall preference would be to build some feedback into the peer review process rather than create more regulatory processes.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I agree that different requirements are needed for doctors at different stages of their career.

Older doctors who continue to work with concerns about their practise are one group. Society does put constraints on older individuals such as in the airline industry (eg pilots) and when driving (compulsory medical certificates). Perhaps a similar aged based oversight could be considered in medicine. The difficulty is the breadth and depth of practice and who sets the standards. Likewise doctors in the first few years of vocational training also would benefit from extra support. Perhaps targeting both these groups in a supportive and non threatening manner might be helpful.

There is also a gap once training is considered completed. I had regular supervision throughout training which was a helpful process. Once qualified, there is no specific requirement for ongoing supervision and I had to arrange this of my own accord without direction or support of the DHB or college. I consider this an important part of safe practice and think there should be room for this within CPD.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I wonder about a requirement for a medical examination every 2 years from the age of 70 and a closer supervision process for doctors to work after this age.

Proposal:
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Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Recertification is important. It needs to be a balanced achievable process that is mangeable with current resources. It must be careful not to over regulate which ultimately will drive down the quality of participation and become a check box exercise.

We already have some structures in place that are very helpful and I think the peer review process could be used to support some of these suggested changes.

Of everything I do currently the peer review process for me is the most useful activity that I participate in. One learns from others and the generated discussion allows one to modify practice in line with other clinicians. It is supportive and educational but creates some tension to ensure quality I the process.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Time and resources are the barrier to implementation. As suggested above if the structure of peer review groups could guide feedback then this might make the amendments less resource intensive.

Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes but requires good and clear communication.

Antonia O'leary

From: Raewyn Gavin - Auckland DHB
Sent: Monday, 30 January 2017 10:04 a.m.
To: Strategic Consultation
Subject: Individual feedback

Below is my personal response to the document. I am a Fellow of the RACP and I suspect there will be one or more official responses from the College also

I think recertification is necessary and should be implemented. I suspect some doctors will be apprehensive about this. Many are likely to be concerned about how much time the process will take.
Any additional requirements on top of what is already required by the Colleges needs to be as user-friendly and efficient (electronic) as possible

In particular, 360 degree feedback is proposed by many and ,if done well, is a useful assessment tool. However most DHBs do not have one and the RACP do not yet have a readily accessible electronic format that can be used. Where I work people sometimes use CME to pay for privately organised 360 degree feedback packages.

Regular Practice Review is likely to be very useful but will need to be standardised and based on some valid standard. This could use up a lot of resource and time.

I agree the medical colleges should have a major role in defining knowledge requirements

Some people will find the process threatening. It may be useful to identify some 'early adopters' who can then share their experience with others over the transition period. You could make it voluntary for existing doctors for 3-5 years and compulsory for newly registered doctors

Dr Raewyn Gavin
General Paediatrician
Starship Children's Hospital
021493273

Consultation on strengthening recertification for vocationally registered doctors

24 January 2017

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.

Purpose of this paper

This consultation paper reviews the current recertification requirements for vocationally registered doctors and proposes new requirements and standards for medical college accreditation that align with the Medical Council of New Zealand's (Council) *Vision and Principles for Recertification.*

Background

Doctors working in New Zealand are respected for the high standard of care they provide and are one of the most trusted groups in New Zealand.[i] The profession and Council need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted. One way of achieving this is by Council setting and recognising recertification programmes.[1]

Council needs to ensure that recertification programmes for doctors are robust, help assure the public that the doctor is competent and fit to practise, and improve the standards of practice. Council achieves this by setting standards and accrediting providers of recertification programmes. The medical colleges, as providers of the programmes, are charged with ensuring each doctor completes their recertification programme and they determine details of audit of medical practice and peer review.

Council has traditionally regarded continuing professional development (CPD) as the key mechanism for recertification. The report to Council by Associate Professor Robert Large in 1997[ii] highlighted the leadership that medical colleges had already begun in this area. However, Council recognises that more focus is required to ensure the effectiveness of CPD activities on performance.

Traditional methods of completing CPD have been shown to be limited in effectiveness.[iii, iv] CPD is more effective when it is linked to baseline performance[v] and when it addresses an individual doctors learning needs[vi]. However doctors do not always recognise their own learning deficits and needs[vii]. Knowledge and performance may also deteriorate as doctors age.[viii] Council's recertification programmes and activities should provide quality assurance and support continuing improvement in performance.

Current recertification requirements

All recertification programmes currently require a minimum of 50 hours of activity per year which must include at least:

- A minimum of 10 hours of peer review.
- A minimum of 20 hours of continuing medical education (CME).
- Participation in an annual audit of medical practice.

[1] Section 41 of the Health Practitioners Competence Assurance Act 2003

Doctors registered in a vocational scope of practice
Doctors registered in a vocational scope of practice meet recertification requirements by participating in accredited recertification programmes provided by their respective medical colleges. Medical colleges are responsible for ensuring that doctors participating in their recertification programmes meet the set requirements.

Doctors registered in a general scope of practice
Doctors registered in a general scope of practice, and who are not in a vocational training programme, meet recertification requirements by participating in the *Inpractice* programme administered by bpac[nz].

In addition to the peer review, CME and audit activities, each generally registered doctor must also:

- Develop a professional development plan (PDP).
- Complete the Essentials quiz (a knowledge test based on Council's statements).
- Undergo a regular practice review (RPR), every three years.
- Complete multisource feedback (MSF), every three years.
- Have a collegial relationship with a vocationally registered doctor.

Vision and principles for recertification

In 2015, Council consulted stakeholders on its *'Vision and Principles for Recertification'*. Amendments were made following the consultation feedback and the final *Vision and Principles for Recertification* were approved and published on the Council website in early 2016.

There was general agreement that recertification activities should reflect each doctor's individual learning needs and support continual improvement in performance. Feedback also indicated support for each doctor having an individualised PDP targeted to their identified development needs.

Vision and Principles for Recertification

Vision
Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support continuing improvement in performance.

Principles
Quality recertification activities are:

- Evidence-based.
- Formative in nature.
- Informed by relevant data.
- Based in the doctor's actual work and workplace setting.
- Profession-led.
- Informed by public input and referenced to the *Code of Consumers' Rights*.
- Supported by employers.

16 February 2016

Feedback from the Council's annual medical college meetings and from submissions indicated a need for Council to provide further guidance about how medical colleges should develop their recertification programmes to align with the vision and principles.

Proposal

Council is proposing to set new standards for recertification programmes that will replace current recertification requirements.

Medical colleges will need to develop recertification programmes that meet these standards and are appropriate for their vocational scope(s) of practice. The leadership of the profession in this is critical. Recertification activities need to be based on doctors receiving feedback within an open and supportive environment. Good feedback within this environment becomes a driver for change.

Profession-led recertification is a privilege that also has responsibilities which include setting standards and ensuring all doctors strive to meet those standards. Recertification should focus on improving the practice of doctors relevant to their specific clinical responsibilities, practice, and the health service settings in which they work.

Recertification activities are formative. Doctors participate in activities in which they receive feedback to guide their individual education and CPD. The feedback is not aimed at assessing whether the doctor is performing at the required standard of competence but rather at supporting continuing improvement in practise.

In order to achieve recertification, vocationally registered doctors will be required to:

1. **Participate in an accredited recertification programme based on a set of requirements.**
2. **Develop an individualised Professional Development Plan (PDP).**
3. **Complete CPD activities to address their PDP.**

To support the recertification model, medical colleges will need to:

4. **Ensure recertification programmes for vocationally registered doctors meet new accreditation standards.**
5. **Provide Regular Practice Review as an option for their doctors.**
6. **Assist doctors to use performance and outcome data to develop their PDP.**
7. **Provide additional support to doctors depending on their individual professional development needs.**
8. **Provide support to doctors to implement their PDP and assess satisfactory progress toward their PDP goals.**
9. **Collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement.**

Note:

10. **Council 'additional criteria' for all recertification programmes will be incorporated into the accreditation standards.**

The details of these proposed requirements are set on pages 5, 6, and 7, indicating how these affect both the individual doctor and the medical colleges.

Proposed requirements for individual vocationally registered doctors

1. Each doctor will need to participate in an accredited recertification programme based on the following:

a. Good quality performance and outcome data to identify individual professional development needs. Qualitative performance and outcome data allows clinicians to reflect on their own performance as well as plan for their on-going learning. At a minimum the following performance and outcomes data should be used:

i. Outcomes from audit of medical practice (participation required each year).

ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires).

iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is a structured conversation with a designated senior colleague. This could extend to Regular Practice Review (RPR) every three years, taking into account the individual doctor's needs.

b. Identification of individual professional development needs, taking into account the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence practise.

c. Career management planning for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement[ix]. Examples of career changes that may be considered include:

- Alterations to case mix.
- Locations of work.
- Hours or shifts.
- A move away from working as a solo practitioner to the more supportive environment of group practice.

A structured conversation provides a good opportunity to discuss career management.

Employers appreciate open discussion on these matters in an attempt to meet the needs of individual employees, teams, and service delivery.

2. An individualised PDP targeted to identified professional development needs.
Doctors will be expected to review their own PDP each year using performance and outcome data (listed above 1.a. i., ii., iii), noting that as they progress their career their learning needs change.

3. Completion of CPD activities to address the PDP.

Proposed requirements for medical colleges

4. Council accredited recertification programmes for vocationally registered doctors will need to meet new accreditation standards based on the following requirements:

a. **Defining knowledge requirements**
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[2], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*. Cultural competence and the *Code of Health and Disability Services Consumer's Rights* are fundamental to the practice of medicine and therefore emphasis needs to be placed on these.

b. **Identifying professional development needs**
Each medical college is responsible for assisting their doctors to use performance and outcome data to identify individual professional development needs. Qualitative performance and outcome data allows clinicians to reflect on their own performance as well as plan for their on-going learning.

At a minimum, the following performance and outcome data should be used:

i. Outcomes from audit of medical practice (participation required each year).
ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires).
iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is for the doctor to have a structured conversation with a designated senior colleague. This could extend to RPR every three years, taking into account the individual doctor's needs.

5. Regular Practice Review (RPR)
Each medical college will be required to provide RPR as an option for their doctors. RPR will be made available to doctors to undertake on a voluntary basis or where closer review and support is indicated. The RPR model may include different components depending on the area of medicine and each medical college would need to develop an RPR model appropriate for their vocational scope(s). See Council's *Policy on regular practice review*.

6. Developing an individualised PDP
Each medical college is responsible for assisting their doctors to use the performance and outcome data (listed above 4b. i., ii., iii.) to develop a PDP that addresses their individual identified professional development needs.

7. Additional support

a. There may be times when doctors require additional support. When identifying an individual doctor's professional development needs consideration must be given to the knowledge of the doctor, the stage of progression in their career,

[2] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

their work requirements and other factors that can influence the performance of a doctor. For example, doctors who have recently gained vocational registration, doctors training in new procedures or a new scope of practice, or the ageing doctor.

b. Career management planning is recommended for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement.[ix] Examples of career changes that may be considered include:
   - Alterations to case mix.
   - Locations of work.
   - Hours or shifts.
   - A move away from working as a solo practitioner to the more supportive environment of group practice.

   A structured conversation provides a good opportunity to discuss career management.

   Employers appreciate open discussion on these matters in an attempt to meet the needs of individual employees, teams, and service delivery.

8. Completion of CPD activities

Each medical college is responsible for supporting their doctors to implement their PDP. This will include ensuring each doctor makes satisfactory progress towards their PDP goals each year.

9. Continuous quality improvement

Each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement.

10. Existing criteria for accreditation of medical colleges

In addition to the proposed model for recertification, the following existing Council 'additional criteria' for all recertification programmes will be incorporated into the accreditation standards. Medical colleges will need to:

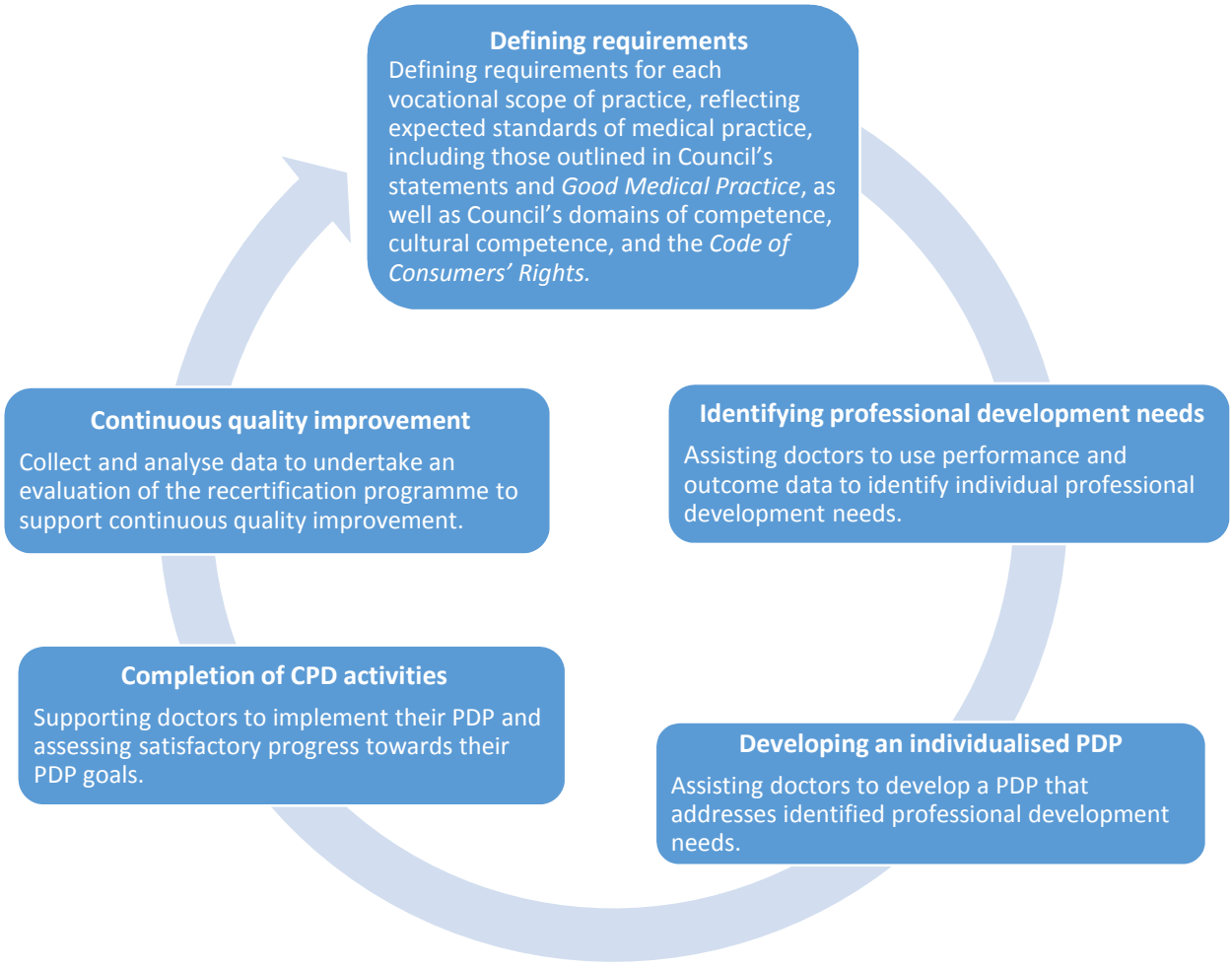
a. Inform Council of the categories of practitioners and numbers of practitioners undertaking their recertification programme.
b. Inform Council of any practitioners not enrolled in recertification programmes.
c. Confirm whether their recertification programme is available for practitioners registered within a vocational scope of practice who are not fellows or members.
d. Have a process for auditing and reporting to Council whether individual practitioners are participating in the recertification programme and whether they are meeting requirements. This includes a system for dealing with those who are not complying.
e. Inform Council of the numbers of and outcomes for practitioners who undertake RPR.
f. Have a system for informing Council if the medical college becomes aware of performance/competence concerns on the part of the practitioner.
g. If the medical college seeking accreditation is not the direct provider of the recertification programme in New Zealand, then the medical college will need to provide evidence that the provider to which they delegate meets Council's requirements.

Transition period for new requirements

Council proposes that the proposed model for recertification is implemented over a transitional three year period. This period will commence from the time Council communicates its final decisions following consultation.

Each medical college would be expected to meet the new standards for accreditation of recertification programmes after this time and will be assessed against the standards when they are next accredited following the transition period.

Proposed model for recertification: medical college responsibilities



Feedback

While Council has provided some guiding questions for submissions, you are invited to provide any feedback you consider is relevant for Council to consider.

A form has been provided for you to complete – see Appendix 1.

You may submit your completed submission via email to:
recertificationconsultation@mcnz.org.nz

Or by post to:
Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submissions may be made until **5pm, Friday 10 March 2017.**

Next steps

Following the close of submissions, Council will consider all feedback. The feedback will inform decisions about the final model, with changes incorporated as appropriate.

Appendix 1

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[3] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

General Questions:

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

This proposal will require a large extra burden of time and documentation for busy doctors, which may impinge on their clinical duties. Is the council convinced that the current system is "broke" to the extent that it needs such a comprehensive compulsory requirement. Accepting that the current system is not perfect and little more than a checklist, are there a lot of bad doctors that are not being picked up it?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

As above. Even the current requirement to document an audit every year is considerably difficult, and time-consuming even for a hospital/university doctor such as myself, even though I am reviewing my practice all the time with colleagues and weekly multi-disciplinary team meetings . I believe adding multi-source review and developing professional development portfolio is going to be taxing for many doctors, and lead to them feeling they have to spend more time jumping through hoops.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Setting a requirement does not of itself lead to a mindset of improvement. Has the Council run this as a pilot on a subset of doctors to assess the time requirement, feasibility and the impact on practice outcomes? This might be done in the three years to provide some basis for adaptation, and would help to show that the Council is itself basing new requirements on evidence-based processes.

[i] Institute for Governance and Policy Studies, Colmar Brunton. 'Who do we trust?'. Victoria University March 2016

[ii] Large RG, 'Maintaining Doctors' Competence. A report for the Medical Council of New Zealand June 1997

[iii] Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P and Taylor-Vaisey A. 'Impact of Formal Continuing Medical Education: D Conferences, Workshops, Rounds and Other Traditional Continuing Education Activities Change Physician Behaviour or Health Care Outcomes?' *JAMA 1999*; *282(9);* 867-74

[iv] Brown CA, Belfield CR and Field SJ. 'Cost Effectiveness of Continuing Professional Development in Health Care: A Critical Review of the Evidence'. *British Medical Journal 2002;324 (7338):*652-5

[v] Davis, D. A, Thomson M.A, Oxman A.D, and Haynes R.B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA: The Journal of the American Medical Association, 274(9), 700-705

[vi] Schostak J, Davis M, Hanson J, Schostak J, Brown T, Driscoll P, et al. (2010) Effectiveness of continuing professional development pro¬ject: a summary of findings. Med Teach;32(7):586–92.

[vii] Davis DA, Mazmanian PE, Fordis M, van Harrison R, Thorpe KE, and Perrier L. 'Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence; A Systematic Review'. *JAMA 2006; 296(9);* 1094-1102

[viii] Choudhry NK, Fletcher RH and Soumerai SB, 'Systematic Review: The Relationship Between Clinical Experience and Quality of Health Care. *Ann Intern Med 2005; 142(4);* 260-273

[ix] Lillis S, Milligan E. The Ageing Doctor. Australasian Journal on Ageing. In Press

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☑ Group □ **Name: David McNamata** **Position/title: Paediatric Respiratory Specialist** **Organisation: ADHB** **Do you agree to your submission, or parts of your submission being published**: Yes ☑ No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☑ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I have a number of concerns about this part of the proposal regards external review. Firstly, for registration purposes all vocationally registered doctors are equal without grades of junior or senior, therefore the phrase "designated senior colleague" should be replaced with a "designated vocationally-registered colleague"**.** Secondly, in the council's policy on regular pratice review it states that this colleague should be a peer who works external to the doctor's site of work. This is not workable. I am a paediatric respiratory specialist. There are 6 of my peers in my current site of work in Auckland. There is only one half-time peer in Christchurch for the rest of the country. It simply is not possible for that one person who lives so far away

to review the rest of us every year. Practice review should be performable by a peer who works at my site of work

Thirdly, with regards to audit. It is difficult to find time to do this. As part of this policy council should be applying pressure on DHBs to ensure that time to complete recertification activities is allowed.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Good idea

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

For those of us involved in specialised care this is redundant because the scope of practice would be so broad. I deal with rare lung and breathing disorders, none of which are frequent enough to be practically defined so my scope of practice would be "any breathing or lung problem"

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No council should not mandate activities. These are likely to differ for each college. For example surgeons may require communication skills while GPs might require procedural skills to be updated.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

I foresee large barriers in that these requirements will require a significant investment of time and effort which will need to come from other work areas; that is doctors will need to give up some clinical work to do this. It is essential that council ensure DHBs as major employers are supportive of this.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Given many colleges are trans-Tasman and Australian medical council has different requirements it is likely to take 5 years to transition.

Antonia O'leary

From: Liam Hughes <Liam.Hughes@nmdhb.govt.nz>
Sent: Wednesday, 25 January 2017 2:00 p.m.
To: Strategic Consultation
Subject: Box ticking

Having moved from the UK where I was a consultant cardiologist at a teaching hospital for 25 years I am familiar with most aspects of the outline proposals.
When obtaining vocational recognition in NZ I was surprised that all medical sub-specialties including cardiology are under one "medical" banner. I presume the relatively small number of physicians in NZ is a factor.
However in NZ there is considerable variability with regard to the number of immediate colleagues (within the same sub-speciality) that doctors will be working with on a daily basis. Clearly those in big centres are more likely to be subject to peer review as part of their clinical practice but sub-specialists in smaller centres may well be solo providers with little regular contact with peers. Perhaps some consideration with regard to the frequency of assessment necessary depending on the sub-specialty and number of immediate peers might be possible.
Certainly working as I was in a department with 14 ! colleagues often sharing lists, attending weekly M and M, audit, educational meetings it was somewhat tedious to present year after year almost identical information at yearly appraisals. Moreover working with both medical and paramedical colleagues in a team provided a rolling assessment of one's clinical practice far superior to any of the somewhat artificial 360 questionnaires and certificates of attendance at conferences (often in exotic locations with some temptation to miss some of the sessions).
Time taken on recertification is not insignificant. One way to reduce the total burden of time lost (cumulatively this amounts to a great deal of clinical activity) would be to issue certificates to departments with the clinical director being responsible for applying on behalf of the permanent members of staff. Departments with excellent appraisals might be given longer periods between assessments and vice versa.
This would also have an advantage when looking at another potential mine-field of this process namely measurement of "outcome data". Although audit provides some information accurate risk adjusted outcome data exists for very few specialities. I would have grave concerns that raw outcome data for an individual doctor could be misinterpreted allowing some dangerous doctors to continue and other safe good practitioners to be falsely accused of doing harm. I would strongly recommend looking at Sam Nashef's book "The Naked Surgeon" that beautifully highlights the dangers and difficulty in measuring both risk and outcomes.
Recertification is good because it makes doctors reflect on their practice(the good ones have always done this) and studies have shown that this alone improves standards of care. However within the UK appraisal (an annual requirement for all consultants) has caused some resentment especially amongst doctors working in teams where a change in their "performance" would be quickly noticed. A system must insure that it doesn't antagonise the 99% good apples to identify the rare bad one.
Kind regards,
Liam Hughes SMO Cardiologist Nelson Hospital

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ ~~Group~~ ☐ **Name: Michael Puttick** **Position/title: Consultant General Surgeon** **Organisation: Auckland District Health Board** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ ~~No~~ ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The aims stated are to be applauded and will certainly broaden the way doctors approach professional development. What is not addressed is the resources that will be required **A similar model for recertification or revalidation has been adopted in the UK. The latest review of this has found that the process is disproportionately time consuming for the amount of benefit it gives in supporting doctors or protecting the public from doctors who do not remain up to date. What lessons has MCNZ taken from Sir Keith Pearson's review of revalidation in the UK and the GMC's response to it?** **In the UK the formative process of developing a PDP and reflecting on feedback takes place in the context of an annual appraisal. There is no mention of appraisers or mentors in the consultation. Is this a role that the Colleges are supposed to provide? Will this be reflected in extra subscription costs to colleges? Will the MECA allow SMOs in DHBs (already under a lot of pressure and at risk of burnout according to ASMS) extra time to fulfil their requirements?**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

A PDP should be developed with a mentor or appraiser, not in isolation. Who is going to take on that mentorship role? The Colleges? Do they have the resources and personnel to do this?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I agree the colleges are the best bodies to set standards

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Again, this will take up a lot of resource and time, and who exactly will do this review? Will we being reviewing our peers in our own time?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal: **Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.** ***Question 5:*** *Do you have feedback about providing additional support for doctors depending on their individual professional development needs?*
The support should be a partnership between the college and Council
Question 6: *Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?*
No
Proposal: **Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement** ***Question 7:*** *Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?*
Who is going to own the data; colleges or Council. Is there evidence to show that more professional development leads to quality improvement or is there an assumption that one leads to another?
Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?*
The aims of the programme are good and the proposals are good (the What) but they are somewhat light on the Who, the How and the When (who will do this extra work, how will it be integrated and when will it

be fitted in to busy clinical practice?)

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Resourcing is the greatest barrier. I would like to see the lessons that can be learned from other systems such as the UK as there are mistakes that can be avoided. In addition, many of the proposed changes (PDP, multi-source feedback and even the idea of formative assessment) come with a learning curve and doctors will need time to get used to using them rather than them being viewed as a tick box exercise and form filling. Therefore I would recommend that tye changes be introduced gradually to allow for that learning curve to take place. My own experience as a consultant in the UK was that it took several appraisal cycles to really get the benefit of the appraisal as I (and my appraiser) learnt the process. After that initial learning however it became a useful exercise and a positive tool.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Please see comments above. 3 years is too rapid and unrealitisic to introduce all of the proposed changes. It will take more than 3 years to introduce them properly to allow for the extra work and to avoid the resentment of the profession. If introduced gradually and well doctors will learn how to use the recertification process for their benefit and view it positively

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☒ Group ☐ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes ☒ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☒ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The proposal for an annual structured conversation with a "designated senior colleague" by peers "external to the doctor's usual practice setting" will be an extremely onerous undertaking. It will not be easy for all specialists to find suitable senior colleagues outside their workplace and to have enough "designated senior colleagues" to meet the needs of all specialists. It is not clear what you mean by "designated senior". A better adjective would be "vocationally registered" colleague. It is difficult enough to find suitable times for an annual structured conversation with one's supervisor at your workplace. Having to also have another conversation outside the workplace will be a logistical nightmare. For this to work it would probably involve employing a number of "designated senior colleagues" who set aside certain days every week or perhaps even employed full time to have appointments for structured conversations with numerous specialists employed in different places.

Given the sheer numbers involved, this is in my opinion an unworkable suggestion. I suggest an annual structured conversation with a vocationally registered colleague. (not "senior" and not necessarily outside the workplace). This could easily be combined with an annual personal performance review undertaken at the workplace with the clinical supervisor.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

ok

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

ok

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

If it is optional then yes I support it.
If it is compulsory, then it would be onerous and difficult to implement for all specialists.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Good idea

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Include limited questions about career planning in the annual PDP and/or in the structured conversation with a vocationally registered colleague to encourage all doctors to consider this.
Additional questions along the lines of "have you considered retiring or reducing your work commitments?" could also be asked at age 55, 60, 65, and then annually.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?*
Be careful that the requirements do not become excessively onerous. Avoid excessive requirements that some countries (such as UK) have adopted. These can significantly contribute to poor job satisfaction and burnout among doctors.
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Yes – see question 1.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*

Antonia O'leary

From: Gowan Creamer <glc124@icloud.com>
Sent: Thursday, 26 January 2017 8:51 a.m.
To: Strategic Consultation
Subject: Feedback

Question 1
a. No comment
B. Are we expecting colleges that span the Tasman to treat doctors in each country differently

2.
Annual review should be considered distinct from annual change.

3.
Some knowledge requirements are the domain of the colleges, however, some are universal e.g.. treaty aspects, patient respect etc. These knowledge requirements should be generated centrally e.g. from AHPRA and NZMC

4.
RPR is expensive in time and money. There needs to be very good evidence for its value

5.
It is clear that specific times in a doctors career are risk times e.g. raging effects, depression etc. Targeted support and assessment are appropriate as applying the same levels of support/scrutiny are resource consuming

6.
At each age different pressures apply. Within the college perspective the early years include establishing a practice; the middle years have leadership roles and later years include moving to retirement. Each doctor has career stage specific areas for development/decision making. I would suggest that these are a progression, and that each of us should be actively learning from this smorgasbord.

7.
The data collected at public hospital level have its scope widened from 'financial only' to 'financial and quality'. The health roundtable and govt already have lots of poor data for analysis, improving that data would be a significantly better approach, and both time and $$ efficient.

8. Alignment with AHPRA is strongly advised.

9. Colleges having two seperate assessment groups for the constituent countries

10.
Yes

Thank you

Gowan Creamer

Strengthening recertification for vocationally registered doctors
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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☐ Group ☐individual **Name: Johan Smalberger** **Position/title:Consultant Anaesthetist** **Organisation: Tauranga Pubic Hospital** **Do you agree to your submission, or parts of your submission being published**: Yes ☐ No ☐No **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐ No
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
A mammoth task. **If done, no guarentee that it will achieve your objective.** **Huge finance and time cost, ? realistic goal.** **Probably a good job opportunity for those of us contemplating semi-retirement.**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Anaesthetists already do that as part of our CME program, not new.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

They are best placed to do so.
Already do that, nothing new.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Anaesthetists already do this as part of CME, nothing new

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

A mammoth task. Will need a infrastructure of note to do this, most specialists that I know have an area of need.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I think a definite plan should be in place for registrars aging into the consultant stage of their career. Some of them really struggle to adapt in the real world and the rigours of reponsibility in the public hospital sector, even more so in the private sector.
I think , in an isolated country like NZ, all newly qualified consultants should be mandated to do an overseas fellowship in order to develope a broader professional outlook.

"Certain activities" are already mandated to all specialists, their should be no differentiation between ages, that is discrimination, would be viewed as no different to a Council expextation that female specialists should have a different career management plan than that of males.

The target, the aging doctor, unfortunately, out of necessity, will be key in managing future projected healthcare needs. Junior doctors are pushing for a maximum 12 hour call shift, who will do the work? Older doctors is a resource that should be carefully looked after, you cannot buy experience.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The requirements , in my view, needs to be reviewed. The traditional way of attending conferences all over the world, is a good social exercise(and expensive) but it certainly does not equip a specialist with what is

required to keep pace with modern day technical and certainly inadequate with re to non-technical skills.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I think it will be an administrative exercise that will change nothing that the Colleges are already doing.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The financial and workforce requirements, those that it is aimed at will circumvent it.
It will have to be driven by "outsiders", local professionals will not risk relationship problems with colleagues they work with on a daily basis. Outsiders cost money and time.
I think the only practical way will have to be a structure where people work together in a friendly atmosphere, positive and not punitive. A punitive system, especially targeting the aged physician, will fail on all levels.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

The requirements bar a few proposed, are already in place.
Isolate what will be "new", and make an assessment after procuring finances and manpower.

Strengthening recertification for vocationally registered doctors
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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **Name: Christopher Jones** **Position/title: Specialist Anaesthetist** **Organisation: CCDHB** **Do you agree to your submission, or parts of your submission being published**: Yes **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
Will council be mandating that DHBs provide us with additional time and resources to allow us to collect the data necessary for this? **Who will pay for the colleges to do this for us?**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I'd much rather the colleges did it than council doing it!

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Who's going to pay for this?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Evidence of benefit would be a bonus. Just turns into another box-ticking, hoop-jumping exercise for the vast majority of us…

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Harmonise with Australia – that way Australasian Colleges only need to update their CPD programmes once, rather than change for NZ now and for Australia at some later date.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Not long enough – currently Australasian college requirements are same for NZ and Australia. Colleges will need to develop different requirements for NZ and Australia, which will take additional time and resource.

Antonia O'leary

From: Oliver Menzies (ADHB) <OliverM@adhb.govt.nz>
Sent: Thursday, 2 February 2017 9:18 a.m.
To: Strategic Consultation
Subject: Consultation on recertification - feedback

Hi,

I have read through the document, and agree with the suggested changes.

Currently there is not that much guidance from the College I am a member of as to how to develop a PDP.
I would like to see that strengthened, given that the PDP is moving to an even more important part of ongoing maintenance of standards.

Oliver Menzies
Geriatrician & General Physician, ADHB
http://www.healthpoint.co.nz/dr-oliver-menzies/

Antonia O'leary

From: Enquiry
Sent: Monday, 13 March 2017 8:14 p.m.
To: Strategic Consultation
Subject: FW: Website Enquiry

One for you

Laura

From: stephen.chalcroft@southerndhb.govt.nz [mailto:stephen.chalcroft@southerndhb.govt.nz]
Sent: Monday, 13 March 2017 1:29 p.m.
To: Enquiry
Subject: Website Enquiry

MCNZ Website contact form submission

Name	stephen chalcroft
Enquiry subject	Registration
MCNZ number (if applicable)	8501
Email address	stephen.chalcroft@southerndhb.govt.nz
Details	Submissions on MCNZ Recertification and accreditation changes 13/3/2017 1) The move to have a more robust framework for ensuring ongoing competencies and fitness to practice are supported. 2) There is uncertainty on how these, or similar measures can be demonstrated to achieve the primary aims without over layering compliance costs. It is unlikely that any key analyses have provided insight here. 3) There is a concern regarding alignment within the relevant colleges. Most are Australian based and produce Fellows/members who can reasonably expect to have their certification recognised in Australasia. My own Society (ANZSGM) is part of the RACP. Comments on the MCNZ proposal from my Australia based colleagues are included below: • It would be desirable for reaccreditation requirements for the Medical Council of NZ, APHRA and RACP to align • The proposal requires a higher standard for reaccreditation by Medical Council of NZ than is required by RACP. • Under the proposal a NZ Fellow could satisfy the RACP MyCPD requirements without satisfying the requirements for reaccreditation by the Medical Council of NZ. • The proposed timeframe of 3 years for its implementation is too fast for it to be considered by APHRA and RACP, a model developed, and policy implemented. Unless NZ delays implementation, it is likely that there will be some period of different standards • From RACP and ANZSGM perspective, we should have the same criteria for fellows in each country in the areas that we have responsibility (ie RACP), acknowledging that this may not satisfy all local requirements. Our fellows in these two countries work quite satisfactorily under different health systems, legal systems, taxation and industrial systems. Stephen Chalcroft Geriatrician Southern DHB.
Copy sent to sender	

Appendix 1
Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.
Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

I do not understand how this could be instituted in my circumstance - ie. private practice radiology. What exactly is "performance and outcome data" in this setting? And how is it to be measured and collected. If this means using the using the Radpeer assessment scoring system, we already use this for our annual peer review, so there would be no change. If this means using some other system, what is it?

How am I to get an external peer reviewer - i.e another radiologist from either a different private practice or the public hospital system to review my work, and what measures does he/she use to measure performance and outcomes? This would be a time-consuming process and if you do not have a specific radiologist in another practice or hospital setting with whom you have a long-term friendship, why are they going to do this on your behalf? And if the reviewer is not from our own practice how are they going to do the review - how do they access the radiology studies for review? It would be a very long-winded process for them to have to come to one of my practice settings and then be given computer access to view the images, particularly if this could not all be done in one 2-3 hour sitting. Simply not a tenable or useful idea.

As far as the outcome and performance data guiding the PDP, this sounds fine except for the same problem that I do not know what form of objective assessment is available for determining the outcomes and performance.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.
Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Assuming this means identifying the areas **you** need or want to review and strengthen, or new areas you want to branch out into, this seems fair enough. However, as in question 1 above I have major concerns as to how these areas are supposedly going to be "identified". I am used to analysing my own work and level of comfort with different exams/procedures and then reading or going to conferences accordingly.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence3, cultural competence, and the Code of Health and Disability Services Consumer's Rights.
Question 3:
What is your view of medical colleges defining knowledge requirements?

This seems reasonable - it's what the colleges are there for; to set the standards we must meet.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.
Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I would only support this if it is on a voluntary basis. I do not see any benefit in my practice setting, but appreciate that for solo practitioners or small groups in remote locations, this may provide them with the security that their work is up to the expected standard. Better to ensure that the standard is met by regular review, than find out the performance is substandard only after a problem arises. But, in a large city setting, with multiple practitioners sharing work and seeing each others reports on a daily basis, I do not see this as useful or necessary

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.
Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I do not really understand what this means. What sort of support? Does this mean relaxing the requirements if someone is struggling to meet them?
Needs clarification.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I do not think this is appropriate. Individuals age at different rates and have different perspectives on their own work-life balance. By meeting the other requirements for CPD the practitioner is showing competence. Doctors already make these decisions and mandating them at specific ages is invidious.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement
Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I find the whole process complex, time-consuming and really adds nothing to the ongoing education I have practised throughout my entire career. The terminology is verbose and unclear. Simplifying the process and allowing greater flexibility in what people do to further their own education and skill-set would be a priority for me, rather than mandating the Medical Council's and College"s ideas of what education should be.

General Questions:
Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

As I have already noted above, I see major challenges.
What are the mechanisms and measures for obtaining performance and outcome data in all the various fields of medicine?
Most of us are far too busy in our daily practices already, so I do not understand where the time is to come from to make these assessments.
External peer review is impractical and very unlikely to be accurate or useful.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

This is a major change - I would have thought 5-6 years is more appropriate.

Appendix 1

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

We are currently doing our CPD via the Royal College of Radiologists. There is no more time left to start another series of tests and requirements.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Meet with the Clinical Leader every 2 years and formulate a PDP.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

They do it reasonably well currently.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Not opposed to it. CPD will do. Any more steps will make it complex and reduce the time available for clinical practise, teaching etc. if done effectively.

[3] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs? Short staffed Radiology departments will need more FTE's if time will be spent on this. Other countries like the UK have done this but I am not sure we should follow suit. if we can obtain funding.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply? good idea - diverting to higher management & teaching - i.e.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

We do a good job via RANZCR. continue the good work.

General Questions:

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

I think that this should be left to the Royal Colleges and not be duplicated.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Time, resources. ~~funding~~ funding for additional FTE's if people are required to spend time on non clinical work.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes - but please avoid duplication - MCNZ or RANZCR should do for most things - not both please.

[i] Institute for Governance and Policy Studies, Colmar Brunton. 'Who do we trust?'. Victoria University March 2016

[ii] Large RG, 'Maintaining Doctors' Competence. A report for the Medical Council of New Zealand June 1997

[iii] Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P and Taylor-Vaisey A. 'Impact of Formal Continuing Medical Education: D Conferences, Workshops, Rounds and Other Traditional Continuing Education Activities Change Physician Behaviour or Health Care Outcomes?' *JAMA 1999; 282(9);* 867-74

[iv] Brown CA, Belfield CR and Field SJ. 'Cost Effectiveness of Continuing Professional Development in Health Care: A Critical Review of the Evidence'. *British Medical Journal 2002;324 (7338):*652-5

[v] Davis, D. A, Thomson M.A, Oxman A.D, and Haynes R.B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA: The Journal of the American Medical Association, 274(9), 700-705

[vi] Schostak J, Davis M, Hanson J, Schostak J, Brown T, Driscoll P, et al. (2010) Effectiveness of continuing professional development pro¬ject: a summary of findings. Med Teach;32(7):586–92.

[vii] Davis DA, Mazmanian PE, Fordis M, van Harrison R, Thorpe KE, and Perrier L. 'Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence; A Systematic Review'. *JAMA 2006; 296(9);* 1094-1102

[viii] Choudhry NK, Fletcher RH and Soumerai SB, 'Systematic Review: The Relationship Between Clinical Experience and Quality of Health Care. *Ann Intern Med 2005; 142(4);* 260-273

[ix] Lillis S, Milligan E. The Ageing Doctor. Australasian Journal on Ageing. In Press

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **X** Group □ **Name: Emily Junck MD** **Position/title: Emergency Medicine Fellow** **Organisation: ADHB** **Do you agree to your submission, or parts of your submission being published**: Yes **X** No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes **X** No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The specific metrics that will be measured in the "performance and outcome data" will need to be defined. While I think this could be a good idea to ensure good care is being delivered, it is very cumbersome to collect this data often, and it could overburden administration staff and directors. **Recognize that a doctors' peers often do not know much about the details of their colleagues' practices. Often, doctors do not work at the same time or even while working at the same time, do not hear any details regarding management and diagnostic decisions.**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

These changes do sound like they will take up a significant amount of time to draft up all these documents, draft the responses annually, and to acquire feedback from multiple parties. The MCNZ should come up with a plan for recertification that is time-efficient yet effective.

In the United States, Emergency Medicine doctors are required to take a test every 10 years to recertify and ensure that they know core Emergency Medicine knowledge as the field changes over time. This could be considered for New Zealand.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I think that is appropriate

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I would need to hear more about what the details of these plans would include, and specifically that for my college, to form a more educated opinion.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Again, I would need to hear the details to form an educated opinion. I do fear that this "assistance" could feel more punitive and restrict doctors to only working in certain locations or environments, when they may be perfectly competent to work wherever they want.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Again, you could consider a recertification exam (see above) similar to the USA.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I think it is appropriate to ask colleges to write guidelines or standards for their members. However, it may be very burdensome on the colleges to have to annually review all this data coming in.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I think it sounds like a good idea overall. However, if this becomes too burdensome for individual doctors, it may drive doctors away from working in New Zealand.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Burden on the doctors individually and on the administrations and departments that they work for. Have a test that doctors need to take every 10 years that is offered by their college. That is the best way to ensure knowledge exists and assess management decisions. Doctors can submit CME, but that does not reflect how well they understood lectures in conferences or whether they were sleeping through them or skipping out early on conferences.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

This is a better decision for directors and administrative staff, but it does sound appropriate for individual doctors.

Strengthening recertification for vocationally registered doctors
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Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X **Name: Chris Lash** **Position/title: ED SMO** **Organisation: CMH** **Do you agree to your submission, or parts of your submission being published**: YesX **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I can not see, at least of ED, how performance and out come data can be collected. I work in an ED with 3-6 SMO on per shift where the RMO may discuss the case with any one of us. With our current system/IT it will not easy or accurately identify which SMO was involved in a particular patients care or out come. Data taken off a shift is unlikely to be related to a particular SMO. This will just generate a set of meaningless data.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence, cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Medical colleges are far more suitable than the MCNZ. MCNZ should listen to colleges.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Given most colleges are Australiasian not just NZ, this is essentially meaning New Zealand Doctors are going to have to complete 2 sets of CME -one to satify our college and then the MCNZ requirements

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

As most colleges are australisian, rather than MCNZ having is own requirements, which seem to be different than the Australian requirements, is it time to consider one regulatory body across australia and NZ??
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*

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PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual x☐ Group ☐ **Name: William Wallis** **Position/title: neurologist** **Organisation: private consultant** **Do you agree to your submission, or parts of your submission being published**: Yes x☐ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes x No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The Medical Council should stay out of specialist college business. The RACP is quite capable of arranging its own recertification. I and my colleagues do not regard the members of the NZMC as competent to add further burdens on our already comprehensive and time-consuming CME programme. We cannot see why the input from the NZMC should be imposed upon us in NZ when our Australian colleagues are not subject to the same. To my knowledge, there is no evidence that NZ specialist physicians are in any way more in need for these proposals than those in Australia, who have always had the same requirements we had before the NZMC convinced the NZ Committee of the RACP to add peer review and audits to NZ members of the RACP. This is all is unwelcome and meddlesome.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I am against this, for the reasons mentioned in reply to question 1.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

RACP should do this but without MCNZ input. The NZMC is not competent to impose additional requirements to those of the RACP.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Only if it is voluntary.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This is unnecessary. The RACP can do this if its members ask for it.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No. It is not the NZMC 's responsibility. The FRACP can do this, if there is evidence that it is useful.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The RACP does this very well, thank you. It does not need the NZMC to tell it how to carry out its own business.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

See above. NZMC is not competent to modify or add to the existing RACP standards of recertification.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Yes, stay out of the RACP's business. I and my colleagues believe that the NZMC is out of touch with the NZ medical profession. The NZMC should have a poll of its members to confirm or refute this impression, which I gain from day-to-day contact with my specialist and GP colleagues. Remaining certified is essential but there are limits to how much one can continue fulfilling the increasing demands of the NZMC and devote oneself to the care of patients rather than toiling under more unproved window dressing the NZMC keeps on thinking up.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

I am against implementation of any of the proposals. Never is better than 3 years, or at least the longer the better.

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Senior Project Manager
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Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group □ [redacted] **Do you agree to your submission, or parts of your submission being published**: Yes □ No X **Do you agree to all or parts of your submission being published if it was anonymised**: Yes X No □
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It is important that a "yearly *minimal performance and outcome*" is defined by the medical colleges, for example at least XX clinics a year, at least YY ward rounds a year.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Proposal:
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Question 3:
What is your view of medical colleges defining knowledge requirements?

I fully agree with this

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

The purpose of PRP needs to be defined. I fear this will be subjected to very subjective judgements.

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Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Extremely important that this "additional support" is defined. I fear this will be subjected to very subjective judgements.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Age should not matter. It should be the same requirements and planning for all.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

No objection.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes

Antonia O'leary

From: Anna Macrae Goodwin <kiwianna64@gmail.com>
Sent: Saturday, 28 January 2017 11:18 a.m.
To: Strategic Consultation
Subject: Feedback regarding proposed recertification changes

Dear Karen,

1. It is my belief that the current standards are more than adequate and the proposed changes constitute an unnecessary and onerous burden for vocationally registered doctors. I would be very interested to know what has prompted the perception from Medical Council that “heightened scrutiny” is needed (or required) with regard to vocationally registered doctors?

2. In a country wherein the greatest danger to patient safety (and health care outcomes) is the "waiting list for medical care” it seems inherently counter-productive to add to the "regulatory gauntlet" of physicians. The waiting list is driven by a greater need for medical care than can be presently served by the existing number of specialists. The proposed changes, like so many of the similar proposals by the American Medical Association, simply waste valuable time for physicians, and have not been shown to actually improve patient outcomes. I would like very much to see definitive data that actually demonstrates how the proposed changes will "improve medical care or protect the public", before any of these changes are implemented. New Zealand has an ageing patient population, and generally speaking, physician salaries are much less than those in Australia, Canada, and America. These factors will perpetuate both the ongoing need for more doctors, and the ongoing struggle to retain these doctors. The proposed changes are thus an onerous burden upon physicians that will likely deter physicians from wanting to stay in New Zealand, and reduce the availability of medical care for New Zealanders.

3. We are all ageing. The concept of needing heightened “police powers” to regulate ageing physicians is ill-founded. Instead of acknowledging the collective wisdom of senior doctors and their value to medicine, the proposal carries with it the implication that all senior doctors are somehow struggling with dementia and need some help to be escorted from the clinic to the “old doctor’s rest home”. This characterisation is ageist, and discriminatory in its intent and potential application. What age does council consider to be sufficiently “aged” to begin implementation of its police efforts? There is actually ample evidence to show that the greatest number of hospital deaths occur when “young” doctors are turned loose on the public. Your proposed policy is therefore not in keeping with actual risk to the public, and is disconnected from reality.

4. Whilst we can agree that it is important to stay current (through ongoing professional education) in a rapidly changing, demanding field, I do not see the purpose of having to conjure a new professional development goal, every year, for bureaucratic scrutiny. My goal, every year, is to learn as much as I am able to learn, and to take good care of the patients I serve. Are highly trained consultants NEVER allowed to say," I am very happy with my professional development, as it is? I am satisfied!”. There is much written about physician burn out and I think this is driven, primarily, by the notion that, no matter what we achieve, it is never enough. This idea is frequently put forth, in insidious ways, by such onerous requirements from government bureaucracies, such as the MCNZ, the AMA, and the ABIM. It justifies the existence of such entities, but does not serve the public good.

5. Having witnessed, first and second hand, professional bullying from my local DHB (and the MCNZ), I am very concerned that these proposed recertification policies could simply give the MCNZ more power to quash physicians with different political or scientific view points, despite how scientifically supportable these viewpoints may be. Such behaviour (and intolerance of different opinion) is not in keeping with a robust democracy, and not in the public good. I would therefore vote “no confidence” in the Medical Councils ability to conduct an unbiased practice review at any point in time. It would be far too easy for the proposed police policies to be used solely for “re-programming” efforts for anyone challenging politically motivated MOH “group think”. There is an implicit “conform or else” connotation in the proposed changes.

6. On a personal level, I have a very unique practice and I am concerned regarding a relative paucity of physicians who could reasonably serve as “peers” to satisfy the new requirements. Would these peers be chosen by the medical council or myself? As the only wholly private medical oncologist on the north island, patients have a choice NOT to see me. Physicians have the choice NOT to refer to me. If my patients are happy and referring physicians are happy with the care that their patients are receiving, please inform me of what other “multi-source” feedback is actually relevant or necessary?

I look forward to your reply.

Sincerely,

Dr anna goodwin

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☒ Group ☐
Name: Matthew Seel
Position/title: Oncologist
Organisation: Waikato Hospital
Do you agree to your submission, or parts of your submission being published: Yes ☒ No ☐
Do you agree to all or parts of your submission being published if it was anonymised: Yes ☒ No ☐

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

A lot of the work done by "colleges" is done by their member doctors. Need to be careful that what is being proposed is not impossible to implement.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Individuals will need guidance on how to do this.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Fair.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Will need clarity about what RPR actually is and how to do it?

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Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

See Q1.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Mandate may be too strong, but I like the "directed" principle.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Uniform data collection systems.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

What is a "structured conversation"?

Also see attached pages.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

See Q1.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Yes.

Proposal

Council is proposing to set new standards for recertification programmes that will replace current recertification requirements.

Medical colleges will need to develop recertification programmes that meet these standards and are appropriate for their vocational scope(s) of practice. The leadership of the profession in this is critical. Recertification activities need to be based on doctors receiving feedback within an open and supportive environment. Good feedback within this environment becomes a driver for change.

Profession-led recertification is a privilege that also has responsibilities which include setting standards and ensuring all doctors strive to meet those standards. Recertification should focus on improving the practice of doctors relevant to their specific clinical responsibilities, practice, and the health service settings in which they work.

Recertification activities are formative. Doctors participate in activities in which they receive feedback to guide their individual education and CPD. The feedback is not aimed at assessing whether the doctor is performing at the required standard of competence but rather at supporting continuing improvement in practise.

In order to achieve recertification, vocationally registered doctors will be required to:

1. **Participate in an accredited recertification programme based on a set of requirements.**
2. **Develop an individualised Professional Development Plan (PDP).**
3. **Complete CPD activities to address their PDP.**

To support the recertification model, medical colleges will need to:

4. **Ensure recertification programmes for vocationally registered doctors meet new accreditation standards.**
5. **Provide Regular Practice Review as an option for their doctors.**
6. **Assist doctors to use performance and outcome data to develop their PDP.**
7. **Provide additional support to doctors depending on their individual professional development needs.**
8. **Provide support to doctors to implement their PDP and assess satisfactory progress toward their PDP goals.**
9. **Collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement.**

Note:

10. **Council 'additional criteria' for all recertification programmes will be incorporated into the accreditation standards.**

The details of these proposed requirements are set on pages 5, 6, and 7, indicating how these affect both the individual doctor and the medical colleges.

I find it confusing how numbering continues

I'd suggest - Doctors pts 1-3
- Colleges pts 1-6
- Note = just a bullet
] could be bullets.

Proposed requirements for individual vocationally registered doctors

1. **Each doctor will need to participate in an accredited recertification programme based on the following:**

   a. Good quality performance and outcome data to identify individual professional development needs. Qualitative performance and outcome data allows clinicians to reflect on their own performance as well as plan for their on-going learning. At a minimum the following performance and outcomes data should be used:
      i. Outcomes from audit of medical practice (participation required each year).
      ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires).
      iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is a structured conversation with a designated senior colleague. This could extend to Regular Practice Review (RPR) every three years, taking into account the individual doctor's needs.

   b. Identification of individual professional development needs, taking into account the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence practise.

   c. Career management planning for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement[ix]. Examples of career changes that may be considered include:
      - Alterations to case mix.
      - Locations of work.
      - Hours or shifts.
      - A move away from working as a solo practitioner to the more supportive environment of group practice.

      A structured conversation provides a good opportunity to discuss career management.

      Employers appreciate open discussion on these matters in an attempt to meet the needs of individual employees, teams, and service delivery.

2. **An individualised PDP targeted to identified professional development needs.** Doctors will be expected to review their own PDP each year using performance and outcome data (listed above 1.a. i., ii., iii), noting that as ~~they progress their career~~ their career progresses their learning needs change.

3. **Completion of CPD activities to address the PDP.**

(for easier readability)

[redacted]

Sent: Wednesday, 25 January 2017 6:05 p.m.
To: Strategic Consultation
Subject: Feedback

Regarding the consultation paper, I feel the current system of audit & CPD are sufficient and the best way forward.

Cheers,

[redacted]

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ☒ Group ☐ **Name: Elena Bishop** **Position/title: Pathologist** **Organisation: Southern Community Laboratories** **Do you agree to your submission, or parts of your submission being published:** Yes ☒ No ☐ **Do you agree to all or parts of your submission being published if it was anonymised:** Yes ☒ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I don't understand what "outcome data" means or how doctor's performance is assessed.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I strongly disagree with this proposal. The last thing doctors need is more bureaucracy and useless "paper exercises" like making individualised PDP.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Yes, medical colleges can define knowledge requirements for vocational scopes.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Sounds like more bureaucracy

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I am OK with that

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

Continuous quality improvement should be part of everyday practice

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I don't understand this question

Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
This new model is cumbersome, annoying, adds unnecessarily to a doctor's workload and does not really assess performance. The solution is to stay with the current model.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes

Antonia O'leary

From: Edward & Robyn Theakston <theakston@value.net.nz>
Sent: Monday, 20 February 2017 1:02 p.m.
To: Strategic Consultation
Subject: Reaccreditation proposals

20/2/17
To whom it may concern: re Recertification Proposals
Can I claim CME points for this ? ?

Dr Robyn Theakston
Urgent Care Physician
NZMC14524

Ph 095219165/0212635771

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.
Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Firstly the Medical Council needs to establish that this planned change will do no harm, in comparison with existing recertification programmes
Is it even feasible for all practitioners to receive compulsory 'external' feedback and peer review? ie Practices already struggling for viability, or Practitioners, particularly in rural areas already stressed to the max and having difficulty complying with requirements?
-Where is the evidence for the accuracy and usefulness of internal vs external peer review?
-What 'outcome data' is to be used; is the source reliable? Is the measurement of 'performance' objectively verifiable, validated, fair and consistent?
-Will practitioners get paid to gather 'outcome data' and undertake 'external peer review' of others and if so, who pays?
*-**Who covers** their clinical practice and that of the practitioner they are reviewing, while they undertake this work?*
-What will happen to waiting times for specialist appointments and surgery? Or, if it comes to that, waiting times for GP appointments; which patients tell me, in many practices have already blown out to 3-4 working days?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.
Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?
This is sensible. Doctors need templates and guidelines for such plans, with flexibility to develop certain sub-specialty interests and recognition of time spent on updates and changes in their field of practice
Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of*

Health and Disability Services Consumer's Rights.

Question 3:

What is your view of medical colleges defining knowledge requirements?

This is sensible

Proposal:

Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

There are already regular quality improvement audits imposed on primary care practices by ACC, Cornerstone etc Our primary care practitioners are already visited and assessed in practices when they are becoming vocationally registered.

This idea has potential to be a massive drain on the workforce resources. As long as it is optional or imposed in cases of exceptional concern about a doctor or practice, it is sensible.

If it becomes universally compulsory; judging from experience with the reviews by GP college, ACC and Cornerstone, it will inevitably impose massive resource costs in time and money.

Practitioners approved by each College will also need to take time away from their own practice to review others and 'somebody' ie the practitioner being reviewed, will have to pay for this.

See above re waiting times and clinical work.

Please note, increased waiting times for clinical care is not a desirable outcome and this needs to be accurately monitored.

[3] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:

Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

It would be good to see more organised learning sessions or more intensive supervision with senior colleagues arranged through the Colleges.

Question 6:

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No.

Each individual should be assessed and reaccredited consistently regardless of age as nobody can predict the effect of one's chronological age on one's practice.

Proposal:

Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

*I totally agree we must establish whether there is a **correlation** between instigating these reaccreditation processes and consistent improvements in clinical **outcomes***

This will involve a thorough and valid analysis of current quality of clinical care and a repeat analysis after implementing the new recertification programme. It should also in my view, involve looking hard at current processes used in evaluating medical practice and what is useful or constructive or otherwise in these processes.

Accurate and relevant outcome data has to be collected; and robust audits are difficult and time consuming to develop. Who actually develops and validates these audits? Who pays them to do it? Is the audit accurately and reliably measuring a clinically meaningful outcome? Is the process duplicating another one already in place, thus wasting Health resources?

In practice, there is a danger that 'continuous quality improvement' is taken to mean that the status quo is unsatisfactory, with evaluation becoming targeted on fault-finding eg What evidence is there that practitioner's skills or clinical outcomes are improved by the regular ACC audits which year upon year impose new compliance requirements ie 'fail' practices on details, which were previously passed by the five earlier auditors?

Another example of a terrible audit currently in place, uses duration of time spent in Emergency Department as a supposed measure of whether the referral from primary urgent care was appropriate or not. Our medical director has to waste valuable time processing this meaningless and unvalidated data and discussing it with us at our Peer Review group. When we analyse these outcomes on a case by case basis we are appalled at how invalid the conclusions are.

The data supposedly auditing my prescribing habits by Pharmac has been consistently inaccurate over many years – who will protect doctors from such inaccuracies and the implications they may have for their professional reputation or increased compliance costs?

General Questions:

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its Vision and Principles for Recertification?

I believe the Medical Council has a duty to examine minutely the feasibility of what it requires from the Colleges
What evidence is there that this will be a cost-effective use of resources of a medical workforce facing real shortages and a Health Service already using rationing to assign clinical services to patients?
This review of recertification needs to be done carefully, expertly, efficiently and thoroughly; and not rushed through in an arbitrary time frame of three years. The logistics and costs of implementation need to be thought through.
Unnecessary duplication of compliance requirements must be avoided to ensure cost-effectiveness. The resources available to each College need to be considered when imposing requirements.
I would strongly suggest a Pilot scheme involving one or two metropolitan centres or some other sampling method, before imposing this on all practitioners in NZ

Question 9:

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?
Many potential problems; see other answers.
My hope is that there will be constructive resistance from practitioners who are trained to critically assess the cost-effectiveness of new management based on 'evidence'; and will wish to see 'evidence' for the validity and integrity of these processes and clear improvements in outcomes. By this I mean measurable outcomes in patient's clinical care not just data on the compliance by doctors with the programme!! A major challenge is that the Council maintains accountability and transparency.

Question 10:

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?
Four years is possibly an appropriate time-frame for a thorough and independent review of the outcome a thoughtfully developed Pilot Scheme for a sample of practitioners.
An attempt to rush through an untried, unvalidated, irreversible and universal overhaul of reaccreditation in three years is very unwise.

[redacted]

To: Strategic Consultation
Subject: Feedback on changes to recertification

Dear MCNZ

Thank you for the opportunity to provide some feedback.

I find the developments worrying as it seems to mirror changes which are now in place in the UK. A large part of why morale is at an all time low among UK medical practitioners is the onerous and stressful recertification process.

This will be essentially a large paper exercise which takes away resources like time which is better spent on patient care. While may satisfy the licensing bodies to have paperwork to show that doctors are held to a high standard but in reality I do not think it will protect patients anymore than what is currently in place.

It will be essential to have pilots to look at feasibility and practicability before any changes are put in place. Please don't rush headfirst into this quadmire. Please strike a balance and help doctors do their job.

Regards

[redacted]

****
[redacted]
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****

Antonia O'leary

From: drange@juno.com
Sent: Sunday, 29 January 2017 5:23 p.m.
To: Strategic Consultation
Subject: Re: Consultation on recertification requirements for vocationally registered doctors

I can't even read the involved information without tiring and skipping things.

As a foreign doctor (US) practicing in NZ, I can't really decide if this would be a LOT more work or just a moderate amount more work. Not enough specifics to consider. Not sure how much consternation would be involved in developing a personal development program...or how much good that would do for the effort of improving medical care here in NZ. Might not make any difference at all, that's for you to decide.

I suppose this might be good for consumers (patients in this case) to reassure them that we are honorable. I wish there were an equal set of honorable criteria applied to the consumer.

I will not be staying in NZ and can't find the concentration in me to finish the survey.
Too much for me to consider at present...just ignore this response, if you like.

Makes me want to retire sooner.

David Range
66294

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual [redacted] **Do you agree to your submission, or parts of your submission being published**: No **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I am supportive of revalidation in general but, having experienced this process in the UK, I have major reservations about the frequency and extent of this process. GMC revalidation in the UK used to take about one week of my time to collect all the necessary information. I would then have an interview to be told that all was well with my work but that the things that mattered most to the delivery of my clinical service, namely the lack of resources/infrastructure/appropriate processes, could not be addressed. In other words, it was a lot of work for no obvious gain for my patients. Indeed, it took me away from clinical work. I am apprehensive that the proposed scheme will similarly waste considerable time without any clinical gain for patients. Is this really the way to identify underperforming/problematic doctors or those needing extra personal support?

Requesting external peer review and multisource feedback annually will divert considerable time and energy away from clinical care. Some of the more senior clinicians in particular will be deluged with feedback request forms such that the process could easily become a tedious meaningless exercise with another source of email requests!

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Again, from previous UK experience of revalidation, it is all well and good having a PDP but if there are no resources/funding etc to implement changes needed, it limits the utility of a PDP in terms of clinical practice?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Fine.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Where do the personnel time and money to do this come from? If it is the Colleges, this will increase already expensive membership fees.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I would support annual performance review after 65 years of age

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

So, this is an MCNZ initiative with the most of the responsibility and expense being devolved to the Colleges??

Question 8: *Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?*
Question 9: *Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?*
I strongly suggest a 2 or 3 year revalidation process or a less demanding (in terms of time) annual review.
Question 10: *Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?*
Yes

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

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Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual **Name: David Glasson** **Position/title: Plastic Surgeon** **Organisation: Bowen Hospital** **Do you agree to your submission, or parts of your submission being published**: Yes **Do you agree to all or parts of your submission being published if it was anonymised**: Yes
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
The assessment of "performance and outcome" is extremely difficult. What parameters will be measured and used? Plastic Surgeons have great difficulty achieving some objective assessment of the non functional aspects of reconstructive surgery, and aesthetic surgery. The fallback position is always the recording of complications (e.g. incomplete excisions, wound dehiscence, infection, haematoma, graft and flap loss, revisions etc.). But this does not record the quality of outcomes in terms of aesthetic result in our work e.g. facial cancer surgery, head and neck cancer, burns, correction of congenital anomalies (craniofacial, cleft lip, hands, genital…), and in elective cosmetic surgery. **A professional development plan will relate to the Plastic Surgeon's scope of practice. The RACS already has in place an excellent CPD compliance program online, requiring verification. I doubt that there is more it can do based on "performance and outcome data", however that is measured.**

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

As a surgeon, I have an individualised ongoing education programme, and I must meet the criteria of the RACS to meet CPD compliance. I decide which meetings are of relevance, in NZ, Australia and other countries. If a recorded PDP is required, along the lines of a mission statement, then I can see no problem. How will it form a "central part of recertification". I would see the recording of compliance with CPD by the RACS as more relevant.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Knowledge requirements should be defined by the Colleges, as they understand the vocational scope, monitor education of trainees, set exams and therefore set the standards that must be reached for admission to a Fellowship in that specialty. The Council has a role regarding expected standards of cultural competence, understanding of "the code", etc..

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

I think the College has a role in RPR, setting a template so that both parties understand the process. It should remain voluntary.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

This probably relates mostly to the doctor who has problems such as mental health issues, physical health problems, undergoing litigation, burnout, or aging …
For poor performance (however that is defined), the Colleges may be able to assist with mentorship.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

An e-learning module, or College seminar, on the effects of aging could be valuable to assist insight into the physical and cognitive effects of aging.
Anyone over 55?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

This is a massive question. For example, at present, every surgeon are required to do a peer reviewed audit of all or a selected part of their practice. This is presented to peers, and verification is passed to the College and recorded. So, the College ensures the audit is done, but does not assess the audit itself. Are you suggesting, for CQI, that the College then assesses the audit and forms a judgment of the quality of each individual surgeon's work. That is unrealistic. All the RACS can do is certify the compliance with all the requirements to meet CPD, and therefore CQI.
The College does already assess the quality of meetings and conferences to decide whether they qualify for CPD points. That is a form of CQI I guess.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

As far as surgery is concerned, for Fellows of RACS, there is already an excellent compliance process for CPD, with quite demanding requirements to be met.
It is beyond the College to set and assess the quality of outcomes of each individual surgeon's practice. That is more the role of craft groups, and hospital department audit groups ….

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

A challenge might be the need for Colleges to employ more people and inevitably costs will be passed on to College members. Who will assess the quality …
We could have 50% of surgeons working, and the other 50% checking on them.
Bureaucracy could be enormous and runs the risk of exhausting the goodwill of people who are already very busy.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

Probably, if it is kept efficient, simple and quick to comply with. Otherwise I predict resistance to it.

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Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual ✓ Group □ **Name: Alistair Gunn** **Position/title: Professor Physiology and Paediatrics** **Organisation: University of Auckland** **Do you agree to your submission, or parts of your submission being published**: Yes✓ No □ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ✓ No □
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I strongly oppose this. There is no evidence that doctors' performance is improved by such detailed and time consuming exercises, and conversely consistent evidence from the USA and the UK that practitioners find it a burden that greatly reduces their morale but has no benefits for them. **The current system is for most people a reasonable balance between the burden of compliance and promoting lifelong learning and development. It is unproven but acceptable for most people.** **Even for the current system, my colleagues who are part time, particularly mothers, find that the cost of compliance in time away from family or work or indeed in money is already excessive.**

I have discussed this proposal with older colleagues in general practice. All of them believe that the proposal is such that they would look to retire rather than take on an such an increased burden. I cannot see why forcing extremely experience practitioners to retire prematurely is desirable.

I have looked up the citations provided in the background document. They are small scale studies or opinion pieces or meta-analysis that are highly unconvincing that they would translate to general clinical quality.

I would like to quote from reference iv: A systematic search for suitable economic studies found only nine studies, of varying quality and with ambiguous use of economic terms. The review indicates that the evidence base simply does not allow any empirical conclusions to be drawn about the economic value of continuing professional development.

That is to say this reference does *not* support any intrusive programme of professional development. Rather, it highlights the lack of evidence for any existing programme. I submit that the consultation document is unequivocally misusing this study.

Reference vi. Is small scale and qualitative. Again the money quote is "There was recognition that there needs to be a move away from tick boxes to the in-depth identification of learning needs". Note the word recognition. This is a purely subjective study based on the opinions of respondents. No actual evidence for or against a change was presented.

Reference vii is a meta-analysis. "Of the 20 comparisons between self- and external assessment, 13 demonstrated little, no, or an inverse relationship and 7 demonstrated positive associations." So, in fact, it highlights mixed evidence. It is not reasonable to conclude from this finding that doctors do not recognise their own learning needs, since in fact a number of studies suggest that they do.

Reference viii. I would like to highlight that all of the conclusions are qualified by _may_. The authors were not at all confident in their conclusions.

I submit that the consultation document is using all of these studies to support conclusions that go beyond the evidence.

First, the conclusions here are largely based on mixed evidence. Appropriately, no firm conclusions were made by any of the authors given the very mixed outcomes. Second, I can find no evidence here or elsewhere for the proposed more intrusive professional development programme.

If we compare 2 treatments, mixed evidence for treatment A does not mean that treatment B should be used instead. A change in practice would need convincing, repeated evidence from RCTs first that treatment B was better than nothing and second that treatment B was indeed better than treatment A across multiple studies.

At present we have nil evidence that the proposed, highly intrusive and burdensome programme of assessment has any benefit, and nil evidence that it is better than the status quo. We should not introduce it under any conditions.

I strongly request that Council rejects this proposal.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Yes. This this an absurd requirement that is based on no evidence at all for benefit.

I strongly oppose imposing this unproven burden.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

This essentially impossible to define across multiple subspecialists, and would be an intimidating amount of work to provide even at an inadequate level of detail.

I do not know everything. Gasp. More; I have never met any medical practitioner who suggests that they do, even in a tightly defined subspecialty. Some of the most worrying near miss events that I have witnessed or experienced in my career arose not from any lack of specialist "knowledge" but from failing to appreciate subtle distinctions or new development that that were only uncovered because the practitioner had the humility to reach out to the community and the most recent literature.

Attempting to focus on core knowledge will not improve care and has a significant risk of making practitioners overly confident in their own knowledge, to the detriment of life long learning and a consultative approach.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

recertification?

This is serious waste of time for which there is no clear evidence. I therefore oppose it. There might possibly be some doctors who practice in isolation for whom this might be the only way to obtain useful feedback.

Even then I would want to see evidence that this approach is beneficial before encouraging it. Most doctors in that situation are part time, and for them this will just increase the compliance burden for questionable gain.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I don't know what this means, or what it entails. The colleges are remote organisations with no role in our day to day lives. Mine is based in a different country. I cannot see how they can easily support professional development.

The only way that they could provide direct support would be through colleagues who are on the ground, so to speak. This being the case, why involve the colleges at all?

If it is envisaged that the colleges, rather than professional colleagues were to provide some undefined level of support, then there is a high risk that 1. It will be a bureaucratic nightmare. 2. Expensive leading to a dramatic increase in fees, 3. Duplicative 4. Ineffective.

The cost of college memberships is already well out of proportion to the benefits. Making this burden even more disproportionate is not a good plan.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

No. Strongly oppose. This is meaningless. Career advice needs to be highly targeted. For specialist practitioners this includes a minute knowledge of subdiscipline expertise that would be valuable in the future. You cannot mandate for that level of finely tuned advice.

For more senior doctors it is very very unclear what is meant, but it looks as if the Council is supporting view of the knowledge and flexibility of older doctors that any reasonable person would consider to be offensive.

There is no evidence provided in the consultation document or that I can find in the literature that any particular activities are better or more helpful for professional development at any particular age.

I therefore strongly oppose this unproven and egregiously patronising proposal.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

It is critical to remember the central finding of all studies of quality improvement. When an index of quality is used as a target, it ceases to be a valid measure of quality.

This is a complex finding. What it means is that once people or organisations are given some measure to target, they will adapt their behaviour to maximise the measured outcome. However, many of the changed behaviours will prove to be inappropriate, and reduce quality in ways that are not measured by the index.

This has been repeatedly proven in industrial and public policy venues.

There is every reason to believe that exactly the same will happen for medical quality improvement. It would therefore be highly unwise to use our measures of quality improvement as targets, and there it would be a serious mistake to start relying on it as an outcome.

I therefore oppose this proposal.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Yes. The current system works well in most cases. The major concern with it is that it is disproportionately increases the compliance burden for part time practitioners. Since they are mainly women, this is a highly gender discriminatory, and no effort has been made to reach out to women practitioners to improve their lives.

Internationally, there is already considerable concern that despite the cost, time and effort poured into recertification programmes, that there is a lack of evidence that they improve or even meaningfully help to maintain professional standards.

I was extremely disappointed at the lack of evidence put forward to support the new proposal. If we are given this level of lack evidence for a new therapy, we are well conditioned to assume that it is invalid, and refuse to introduce in to practice. We are the Guinea pigs for this experiment. In the absence of information we should not give informed consent, and if we do, any ethics committee would concur that if we did because we were bamboozled it was invalid.

The current proposal is not evidenced based. It shows considerable signs of increasing the compliance burden. No proposals are included to mitigate the burden on women and other part time practitioners.

As an experienced practitioner who has complied with the current programme, I strongly oppose introducing an unproven programme that is worse for us than what we have.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Yes, this proposal is a bad idea that will reduce medical morale and reduce quality of care by diverting doctors from care to appearing to fulfil the programme. Please don't do it. Seek evidence for strategies that are proven to improve care and do not impose a large burden.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

No. 3 years is much too short. The proposal is premature and extremely burdensome. The concept should be completely revaluated to provide a better quality refinement of the current approach.

Antonia O'leary

From: James Herdman [HVDHB] <James.Herdman@huttvalleydhb.org.nz>
Sent: Wednesday, 1 March 2017 4:13 p.m.
To: Strategic Consultation
Subject: Submission on recertification for vocationally registered doctors

Please find below my submissions to the questions posed on the MCNZ document "Strengthening recertification for vocationally registered doctors"

Question 1:
I'm not convinced that compulsorily using performance and outcome data, or multisource feedback will further inform PDP development. Especially for doctors who are senior and seasoned. Its trying to standardise a highly subjective process, and will simply add more work, more bureaucracy to an already bureaucratic process. We already have feedback from peer review and supervision, as well as the option to have a practice review. Meaningful performance and outcome data is hard to come by or interpret in some specialties particularly those dealing with chronic health issues, or with the most severely unwell and disabled. And to be providing such data every year will come around so quickly as to be of questionable validity.
As for 360 degree reviews, these have to be quite skilfully designed to be at all useful, or they can easily simply reflect personal likes and dislikes rather than anything objective about quality. Again, the idea of doing these annually seems excessive.
I cannot see what is wrong with the existing process done through the medical colleges. Is there any evidence whatsoever that adding another layer of regulation is going to add quality to the profession, or simply produce another bureaucratic task to enable ongoing certification?

Question 2:
Specialists already develop an individualised annual PDP.

Question 3:
Medical Colleges already define knowledge requirements in terms of training needs. Its less clear how they can define such a varied and individual matter for those who are vocationally registered, especially if more senior. Also, my experience is that the colleges are skewed towards the Australian system and don't always have a good understanding of the NZ environment, the public health system here or cultural differences

Question 4:
This is already an option with RANZCP, and could be an option for any medical college.

Question 5:
Sounds reasonable

Question 6:
It is not possible to mandate activities to a certain chronological age, and could be seen as ageist and discriminatory if crudely applied. Many specialties gain from the wisdom accrued by senior doctors in their later working lives. It is a complete waste not to make use of this, or to make re-certification requirements so arduous that it becomes impossible to continue beyond standard retirement age. In fact this is one of the reasons many doctors look to early retirement after the age of 55-60 yrs. What is more important is that doctors are encouraged to maintain their own mental and physical wellbeing, that's the best protection. There may be some specialties that are physically arduous and require guidelines for certain fitness levels. Equally, some are psychologically demanding and need acknowledgment, but this is not a matter simply of age.

Question 7:
It seems sensible to gather data on any such scheme to evaluate how useful or appropriate it is.

Question 8:

OK in principle

Question 9:
Fatigue and lack of buy-in could render the process mechanical and unhelpful, just another task to complete to satisfy somebody else's requirements rather than owning it oneself. There have to be demonstrable gains and benefits.

Question 10:
Maybe.

Overall:
I am not at all in favour of increasing the burden of processes and bureaucracy attached to ongoing accreditation. Its not often one hears of such processes being streamlined or simplified instead of incrementally being added to. If they are partly designed to protect the public, I doubt any of these processes would have picked up some serious offenders in medical practice eg Harold Shipman, mass murdering GP in the UK, or Morgan Fahey, Christchurch GP and serial sex offender, not to mention your average underperforming doctor. These are much more likely to be picked up locally by colleagues, individuals or institutions than the regulatory bodies themselves in the first instance. Good doctors don't need more regulation, and existing PDP processes through the medical colleges seem largely adequate, alongside the multiple quality improvement activities that exist. Medicine is one of the most regulated of all professions, rightly so, but it would perhaps be good to turn the focus on some other groups who have significant public impact, people in the corporate sector, politicians, lawyers, tradesmen!

I hope this is helpful.

Dr James Herdman MA MB B.Chir MRCGP MRCPsych AffiliateRANZCP
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Consultant Psychogeriatrician
Hutt Valley District Health Board
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Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information

This submission is on behalf of: Individual ☒ Group ☐
Name: Dr Daniel Ching
Position/title: Consultant Rheumatologist
Organisation: Timaru Medical Specialists Ltd
Do you agree to your submission, or parts of your submission being published: Yes ☒ No ☐
Do you agree to all or parts of your submission being published if it was anonymised: Yes ☒ No ☐

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

If you intend to use performance and outcome data, multisource feedback and external peer review to identify professional development needs, do you have published evidence that this results in better performance and outcomes? This will involve a lot of work for the doctors concerned. You are putting this onto medical colleges who would then have the enlist other similarly vocationally registered doctors or specialists to do this work. This is a lot of work, and I doubt if anyone would do this for free, or would do it well for free. If medical colleges have to pay this for this, it would obviously increase the cost of our subscription. If the Medical Council is going to pay for this, I assume you would subsequently increase the cost of the annual practising certificate.

For a speciality where there is a real shortage of specialists in New Zealand such as Rheumatologists, the

significantly extra work in complying with this will reduce the time we have available to spend on patient care and will ultimately affect patient care.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I disagree that every vocationally registered doctor must develop an individualised Professional Development Plan (PDP) and to review it every year. It think it varies from doctor to doctor. At present, I currently do 5-6 times the minimum requirement for CPD per year for the Royal Australasian College of Physicians, and I probably miss recording out other activities I have forgotten to note. I run a large rheumatology therapeutics clinical trial centre, and I know what I need to do to keep up to date with my area of research, and this type of research is also very relevant for my practice. As a result of the standards required for clinical research, this obviously impacts and raises the standard of my clinical practice. I have no intention of changing my clinical research nor practice at present for the foreseeable future, and therefore, my PDP will not change for the foreseeable future.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

The Royal Australasian College of Physicians cannot define the knowledge requirements for my practice, but might be able to do this for general physicians. They are entirely dependant on our specialist society i.e. New Zealand Rheumatology Association, in defining our knowledge requirements. I do support and subscribe to the Council's statements of Good Medical Practice, Council's domains of competence, cultural competence, and the Code of Health and Disability Services Consumer's Rights.

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

While Regular Practice Review is a good option, it requires a lot of time and travel for a colleague to do Practice Review. This will again impact not just on the cost of subscriptions to medical colleges, but also the doctor's time and thus his or her ability to provide patient care.

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

It is an ideal system to provide additional support for doctors depending on their individual professional needs, but you have to take into account the cost to the medical college and ultimately the fellows of the medical college and the impact this will have on patient care. I think it varies from doctor to doctor and this additional support is not required for every doctor.

It is important that the Medical Council is not seen to be accused to ageism. All of the doctors near the age of retirement might not want to withdraw from clinical work or transition into retirement, and some might want to retire well past the age of 65. Some perform very well as a solo practitioner and do not need a 'more supportive' environment of a group practice and in fact might find the environment of a group practice to be more of a hindrance in achieving a higher standard of practice. In this electronic age, it is easy for a solo practitioner to see a second opinion and work with colleagues, not just in New Zealand, but abroad.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

Council should not mandate certain activities such as doctors age, because you would be accused of ageism. I think it varies from doctor to doctor. Some of the best doctors practising in their field are well past 65 while some younger doctors might not practice to as higher standard.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

It is all very well for you to impose this on medical colleges as an idealistic concept, but you have to think of the practicalities of your proposals. If you expect medical colleges to do all of this work, there will be a cost. I suggest you approach the government for appropriate funding for your proposals. I would also like to see evidence that your proposals will improve the quality of practice. I say this because I am conscious of a colleague who has been through 4 competency reviews and has passed all of her CPD requirements annually for 2.5 decades, but was still able to practice. My opinion is that all Medical Council reviews of competency were totally ineffective in this case before she finally left the country and retired.

Question 8:
Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

I think the Council's proposals are idealistic without considering the practicalities. It is important the Council is not seen to be biased against the ageing doctor, because the way you have worded your proposals is suggestive of this. It is also important you don't think or assume that solo practitioners are not in touch with other colleagues and are not as well supported as in a group practice in this electronic age or solo practitioners don't practice to as high or better standard than doctors in group practice.

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

The big barriers and challenges to the proposed recertification model is the cost and time required for this massive increase in compliance work to renew our annual practising certificate. To address these issues, the Medical Council need to seek extra funding for its proposals, possibly from the government. You will also need to ask the government to increase the number of spaces for each medical school and for Waikato Medical School to start up in Hamilton. You simply need to have more trained doctors to do this extra work without impacting on patient care.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

3 years is an inappropriate and impractical transition period because it takes a lot more than 3 years to train new doctors. You need a lot more vocationally trained and 'senior' doctors in order to carry out your proposal, assuming you can get extra funding to do all of this from the NZ government.

Strengthening recertification for vocationally registered doctors
Consultation Feedback Form

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors by responding to the questions below.

Deadline for submissions: 5pm Friday 10 March 2017.

Please complete the feedback form and return via email to recertificationconsultation@mcnz.org.nz
Or by post to: Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submission information
This submission is on behalf of: Individual X Group ☐ **Name: Melissa James** **Position/title: Radiation Oncologist** **Organisation: CDHB** **Do you agree to your submission, or parts of your submission being published**: YesX No ☐ **Do you agree to all or parts of your submission being published if it was anonymised**: Yes ☐ No ☐
Guiding questions for submissions
Proposal: **Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.** ***Question 1:*** *Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?*
I agree with the sentiment, that a learning plan we guided by data. I am concerned however about how achievable this is especially in a small specialty with a lot of subspecialisation. I support the idea of the colleges assisting the doctors to do this, as it is the college that is most aware of possible benchmarks for practice.

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

I feel this is sensible and useful as it links CPD to individual learning needs.

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[1], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

I believe if this is to be required the colleges are best placed to do this for their speciality

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

Although I think good in principle, this would in fact be very onerous for our specialty, which is fraught with workforce shortages. I believe that to do this well, would require very thorough work by another fellow from the specialty and would need to be resourced appropriately (both in terms of time and financially)

[1] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

I disagree that an "underperforming" doctor is the remit of the specialist college. The college do not employ and thus I believe an underperforming employee must be supported/managed by the employment body. Support and advice should be sought from the college and guidelines/ policies should be in place for this, but the ultimate responsibility lying with the medical council/ employer.

Question 6:
Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

I think the adoption of age as the flag for mandating certain activities introduces an unnecessary prejudice into the system and one subject to a very wide range of individual variation. I believe that the programme itself should be used to detect issues that may require learning goals/ experiences across the board and that we trust these processes to detect and deal with issues, whatever the age of the practitioner.

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

I do not fully understand this statement- is it the college must keep individual data or data on their programme- eg compliance etc??

Question 8:

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

i. Outcomes from audit of medical practice (participation required each year). ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires). iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is a structured conversation with a designated senior colleague. This could extend to Regular Practice Review (RPR) every three years, taking into account the individual doctor's needs.

I feel that number II is helpful and structures already exist in colleges to support the MSF

I am hover unsure of what is meant by the audit of medical practice each year and I believe that III is very onerous as explained elsewhere

Question 9:
Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

Yes. This represents a huge change from our current practice. The implications are huge in terms of the resource to develop the college required policies, programmes. I am also very concerned that is a small specialty as ours is, with an already known high rate of burnout, the additional requirements to maintain our own practise and assess in detail other colleagues practise may have the system beyond break point. I also raise the question as to the problem we are trying to solve- is there evidence of underperforming of doctors or are we creating a system to address theoretical issues? I also ask who pays for this. Are doctors going to be given addition FTE to complete these requirements and are colleges going to be give additional financial support to do the work required? I am concerned that these requirements may actually lead to decreased patient care as doctors will have to make short cuts to patient care to fulfil onerous re certification requirements and colleges may need to divert funds away from training and teaching in order to fulfil these requirements.

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

No I do not believe so. There is an enormous amount of work to be done if this programme is to be implemented, with the demands on an already overworked medical workforce very significant. I would be in favour of a more staged implantation over a 5 year period with intermediate milestones set.

Antonia O'leary

From: George Symmes
Sent: Monday, 13 March 2017 7:51 a.m.
To: 'bagshaw@clear.net.nz'; Karen Davis
Subject: FW: Consultation on recertification requirements for vocationally registered doctors

Dear Dr Bagshaw

Thanks very much for your email and comments regarding our *Consultation on recertification requirements for vocationally registered doctors* which we have received.

With very best wishes

George

George Symmes | Communications Manager
Medical Council of New Zealand |80 The Terrace | Wellington 6011
PO Box 10509 | The Terrace| Wellington 6143 | 0800 286 801 ext 782 | DDI +64 4 381 6782 | 027 441 55 88| gsymmes@mcnz.org.nz

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From: Philip and Susan Bagshaw [mailto:bagshaw@clear.net.nz]
Sent: Sunday, 12 March 2017 5:51 p.m.
To: George Symmes
Subject: FW: Consultation on recertification requirements for vocationally registered doctors

To the consultation committee of the Medical Council
This submission is made by a primary care practitioner who has worked in New Zealand since 1982 in the fields of addiction medicine, Family Planning and sexual health, and Youth Health.

There are a few points that I would like to contribute to this review which I hope are helpful

1) This process is very resource intensive and for doctors who are already short on time it is going to increase their workload and add to their stress levels as their workplaces will not allow them time to complete.
2) Senior colleagues with time to supervise are scarce and the more senior you become the scarcer they are. This is an important point as the more senior the doctor is the more they are likely to feel they do not need supervision or any professional development
3) The most important reason for doctors to be able to show that they maintain professional and up to date practice for their patients. The benefit to the public (ie the public face of the profession) is secondary
4) Vocational scopes do not match the existing Colleges. My College is irrelevant to my practice and provides no assistance to enable me to maintain expertise in the field I now practice in.
5) It is important that any recertification must be strengths based. Ie it needs to be orientated around making practice improve. If recertification becomes a tick box (even more than now) and you do it or you are "struck off" then if too intense the public may find it has even less doctors to count on rather than better ones.

6) The new suggestions for recertification will require a lot of administration. Where is the resource for this coming from? – This will mean even less going in to actually providing a service for people. We have enough unmet need as it is. The cost of the new system to the public must be considered. If doctors in primary care are charged more to recertify this will be handed on to patients and 20% can't afford a GP as it is. If handed on to the hospitals we will see more people who don't get a first specialist assessment, or an operation. Standards and professional practice and new learning must be ensured but not without more resource for this to happen effectively.

Thank you for the opportunity to contribute

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Antonia O'leary

From: Peter Ripley <drpeterripley@gmail.com>
Sent: Tuesday, 21 February 2017 7:16 p.m.
To: Strategic Consultation
Subject: Question 4 feedback, hope this is useful.

Dear MCNZ,

Question 4:
========
"Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?"

As someone undergoing regular routine practice reviews through valuable and cost-effective BPAC InPractice programme, two so far, I'm surprised that the credibility of recertification is undermined by RPR being proposed as optional. The ones needing it the most will tend to opt out, and a patient can surely only be reasonably reassured by a quality-assurance activity that his/her doctor can be safely presumed to be doing.

In particular in regard to RPR I refer to the Practice Visit, which involves observed consultations, review of random clinical notes and interaction with the reviewer about matters arising. Everything else (audits, CME, Prescribing reports, peer review groups, surveys forms completed by largely loyal patients and by self-selected colleagues) is relatively toothless at identifying difficulties an individual doctor may be reluctant to volunteer.

As a General Registration doctor, I assumed the InPractice program that was foistered on us would be up to scratch, and it has proven itself to be useful and it is still improving. Lately I have re-formed my opinion that InPractice is excellent, insofar that the RNZCGP's MOPS programme does not include practice visits despite the programmes' similar participation cost. Is it not surprising that General Registrants should find themselves as the avantgarde of quality assurance? That said, we are a more vulnerable group of doctors and were basically told to do it. Whichever way it came about, I'm in the water now and I can reassure my vocationally registered colleagues, vocationally trained and grandfathered alike, that RPR is really no threat but something formative, encouraging - and even useful.

Yours sincerely,

Dr Peter Ripley - 31340

[redacted]

Sent: Wednesday, 25 January 2017 5:29 p.m.
To: Strategic Consultation
Subject: Re: Consultation on recertification requirements for vocationally registered doctors

I do have some general comments on the Councils proposals. I am not filling out the form on your website as I have more far-reaching comments.

There seems to be general assumptions that the current re-certification requirements are not enough to ensure the ongoing competency of vocationally trained doctors. I assume there is evidence to support this? In terms of the changes you are proposing, as we live in an evidence-based world, *what is the evidence that supports your changes will result in better medical care? Do you have outcome studies?*

And if, on top of this, you create a further burden for older doctors to prove their competency what are your plans to cover the shortage of doctors? Why should older doctors be held to a higher standard if they are able to meet the PDP requirements their younger colleagues meet? And how will you define "older"? We all have the experience of seeing that there is a vast difference in terms of how people age.

As it is, the predicted number of older doctors planning to retire from medicine in the next decade is staggering. What are the plans to fill these shortages which will surely increase, given the medical council's plans? Are you just going to keep recruiting more foreign doctors instead of holding on to the doctors you have? While there is a lot of talk of " protecting consumers" let us not forget that society as a whole has already *made a huge investment to produce doctors.* This is a *two way street* and it behooves society to support medical professionals. I personally find that the idea that the medical council is there to "protect" the public from doctors, suggesting almost a criminal overtone, to be offensive.

And is it really appreciated that medicine is not just technical learning? When you lose an older doctor you lose 40+ years of accumulated experience, skills and learning all at the time when the population itself is also aging rapidly (the over 85 population is expected to increase *six-fold* in the next 25 years). I would submit that at least in primary care the older doctor is in a unique position to provide more appropriate care to the elderly.

And finally, if we are talking about protecting the public, is there any data/studies to show what the public wants? Have we had adequate robust input from the non-medical public (not just bureaucrats in government positions) as to what would type of continuing certification they would like to see in place?

Thank You,
[redacted]

On Wed, Jan 25, 2017 at 12:27 PM, MCNZ - Vocational Recertification Consultation <mcnz@mcnz.org.nz> wrote:

25 January 2017

Dear Colleague,

Consultation on recertification requirements for vocationally registered doctors

The Medical Council of New Zealand (Council) is reviewing the current recertification requirements for vocationally registered doctors and proposing new requirements and standards for medical college accreditation.

You are invited to provide feedback on Council's proposal to strengthen recertification requirements for vocationally registered doctors.

You can view and download the consultation paper and feedback form on Council's website at:

https://www.mcnz.org.nz/news-and-publications/consultations/consultation-on-strengthening-recertification-for-vocationally-registered-doctors/

Feedback on the consultation can be emailed to recertificationconsultation@mcnz.org.nz.

The deadline for submissions is **5pm Friday 10 March 2017**.

Yours sincerely

Mr Andrew Connolly
Chairman
Medical Council of New Zealand

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