New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143

By email: SConsultation@mcnz.org.nz

Strengthening recertification for vocationally-registered doctors in New Zealand

Dear Carol

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,000 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. We note that the current consultation follows on from Council's 2017 consultation on strengthening recertification for vocationally-registered doctors. The NZMA provided substantive feedback on the 2017 consultation;[1] this submission draws on many of the points we made then. While we are pleased that some of our previous concerns appear to have been addressed, we are disappointed that several of the issues we raised appear to have been ignored—particularly those relating to Regular Practice Review (RPR) We elaborate on these concerns in the following paragraphs and provide responses to the specific questions in the consultation.

Overall goals for the changes being proposed and evidence to support proposals

2. We have previously sought clarification on Council's overall goals for the changes related to recertification that are being proposed, as well as evidence for the effectiveness of the proposals Council is advancing. These aspects are important as part of making an effective case for the need for the changes being proposed. While we welcome Council's responses in these areas, we continue to have some concerns around the lack of evidence for proposals that will have major compliance costs.

[1] NZMA. Submission to the Medical Council on Strengthening recertification for vocationally-registered doctors. 19 March 2017. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0005/53618/NZMA-submission-on-strengthening-recertification-for-vocationally-registered-doctors.pdf

26 The Terrace, PO Box 156, Wellington 6140 | Tel: (04) 472 4741 | Fax: (04) 471 0838 | Email : nzma@nzma.org.nz | **www.nzma.org.nz**

3. While Council believes that recertification is both a quality assurance and quality improvement process, we understand that the overall goal is to provide assurance of the competence of doctors, support the maintenance of high standards of practice and strengthen accountability to the public. Despite sharing a literature review of the evidence relating to recertification activities, we note that Council acknowledges that recertification is an area in which best practice is still emerging, and there remains a significant lack of agreement about the design and form that it should take.

Costs of proposed changes

4. While we welcome Council's recognition of the importance that any change does not create administrative burden, duplication of processes or added layers of bureaucracy for doctors, we continue to believe it is incumbent on the Council, as the regulator, to provide robust external assessments of the financial costs of its proposals. This needs to include the work done by all parties concerned, including the colleges. We reiterate our request for Council to clarify expectations around who is envisaged to bear these costs.

Regular Practice Review

5. Despite our concerns about a 'one size fits all' model, Council is continuing to propose that each medical college will be required to provide Regular Practice Review (RPR) as an option for their doctors. We continue to believe this approach is 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.

6. 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.

7. While RPR may be feasible for some areas of practice, it is impractical for some colleges. We understand that several colleagues have conveyed their concerns with the proposal to provide RPR—even as an option. We reiterate our request for Council to clarify what it envisages by way of RPR for colleges such as the Royal Australasian College of Medical Administrators, the New Zealand College of Public Health Medicine or the Royal College of Pathologists of Australasia.

Use of performance and outcome data

8. While we are supportive of using performance and outcome data from audit of medical practice to inform professional development needs, Council does not appear to have addressed our previous concerns regarding potential confounding factors. We ask Council to explicitly acknowledge the importance of recognising and adjusting 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.

Professional development plans and multi-source feedback

9. We note that Council is still proposing the use of a professional development plan (PDP) to guide learning as a core component of a strengthened approach to recertification. While we are generally supportive of PDPs, we continue to have some reservations about the need, cost, value and effectiveness of PDPs for all vocationally-registered doctors. While PDPs may be excellent for younger clinicians who are developing their skills, we reiterate our request for 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?

10. We have previously conveyed our broad support for using the results from multisource feedback (MSF) 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. We would welcome recognition of these concerns by Council as it progresses this work.

Ageing doctors

11. We welcome Council's apparent decision to not pursue its previous proposal for 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. We would like to see Council adopt our previous suggestion for further work to ensure retention of the value and contribution of older doctors while recognising and managing changes related to ageing.

Cultural competency and ethics

12. We have previously suggested that cultural competency be incorporated in all recertification programmes. Rather than requiring individual colleges to develop their own cultural competency programmes, we felt that a single programme could be developed and then shared. Likewise, we suggested that the NZMA Code of Ethics should also be incorporated in all recertification programmes. While Council appears to have adopted our suggestion with respect to the NZMA Code of Ethics (by suggesting it be included as part of 'essentials knowledge' for recertification programmes), we contend that Council should also stipulate the need for cultural competency as part of 'essentials knowledge' for all recertification programmes.

Clinician's annual review process diagrams and other feedback

13. We do not support use of the term 'consumer' in these figures and submit that Council replace this term with 'patient' or, where that is not appropriate, 'public', 'people' or 'individuals'. For example, in the first panel in the figure on page 9, we suggest that Council replace 'Consumer' with the term 'Patient'. For the heading of the first column, we suggest Council amend this to 'Public / patient engagement and participation'. With respect to the second figure on page 9, we would welcome clarification on what 'service manager's feedback' means. We suggest Council consider incorporating mention of the Treaty of Waitangi in these figures. With respect to the seventh point on page 6, we believe the word 'should' needs to be replaced by 'must' such that the sentence reads: "Recertification must be supported by employers".

Consultation questions

1. What are your thoughts about the key components of the proposed strengthened recertification approach?

We note that Council is proposing the following key components as a strengthened approach to recertification:

-A profession-led approach, appropriate to scope of practice.
-Increased emphasis on evidence, value of activities & peer review.
-Education and development relevant to workplace and career planning.
-Use of a professional development plan (PDP) to guide learning.
-Offering regular practice review.
-Specified CPD hours and type.

We are generally supportive of the above components but draw attention to our concerns around regular practice review (see paragraphs 4-6) and professional development plans (see paragraph 8).

2. What suggestions do you have about how these key components could be implemented in recertification programmes?
While RPR may be feasible for some areas of practice, we contend it will be impractical for some colleges (see paragraphs 4-6).

3. Do you foresee any challenges with implementing the proposed approach? What are these and why?
Yes. We foresee major challenges with implementing RPR for some Colleges and/or in some vocational areas. We elaborate on these in paragraphs 4-6.

4. Are there any specific implementation concerns for recertification programme providers (in most cases these are medical colleges)? Do you have any suggestions about how these issues could be resolved?
See our responses to questions 2 and 3, above.

5. Do you think there are any recertification activities that should be mandatory for all doctors?
Yes. Currently, vocationally registered doctors must participate in an accredited recertification programme appropriate to their scope of practice, supported by employers. It would seem reasonable to retain this requirement. The need to base recertification on doctors receiving feedback within an open and supportive culture is also worth preserving.

6. What kind of peer review programmes might work best for you/your organisation? Do you foresee any issues for recertification providers to offer RPR as an option for doctors?
See our responses to questions 2 and 3, and our concerns with RPR (see paragraphs 4-6).

7. Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?
We are pleased to note that Council appears to have withdrawn its proposal for mandating certain activities as doctors age. We suggest that Council may wish to give specific consideration to requirements for doctors that practice part-time, especially during child rearing, for example.

We hope that our feedback has been helpful and would like to be kept informed of this work as it progresses.

Yours sincerely

Dr Kate Baddock
NZMA Chair