New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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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

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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.

[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