



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: 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 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?

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.