



18 October 2018

Submission to the Medical Council of New Zealand:
Strengthening recertification for vocationally-registered doctors in New Zealand

The New Zealand College of Public Health Medicine (NZCPHM, the College) thanks the Medical Council of New Zealand (the Council) for the opportunity to make a submission on the document 'Strengthening Recertification for Vocationally-Registered Doctors in New Zealand'.

The NZCPHM is the professional body representing the medical specialty of public health medicine in New Zealand. We have 236 members, all of whom are medical doctors, including 183 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

Background

The NZCPHM recognises the importance of systems that provide assurance to the regulator and the public that medical practitioners are maintaining their competence and continually seeking to improve their practice.

We agree with the Council that any changes to current recertification requirements should not create an additional administrative burden, duplication of process or added layers of bureaucracy.

We support the Council's Vision and Principles for Recertification, published in 2016. We appreciate and support the Council's 'high trust' approach to recertification.

We further support any developments which move away from a 'tick-boxing' approach to recertification and would encourage a move in the direction of activities which have clear and obvious relevance to medical practitioners ('face validity'). Activities which are perceived to be relevant are more likely to ensure positive outcomes and behavioural change.

Consultation questions

Our responses to the consultation questions are provided below.

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

1.1 A profession-led approach, appropriate to scope of practice

The NZCPHM agrees with the Council that medical colleges are the most appropriate bodies to determine the types of activities that are relevant to, and should be undertaken by, doctors in that scope of practice.

We note the suggestion that doctors should be able to map their continuing professional development (CPD) activities to their scope of practice, usually by reference to a college curriculum. A college curriculum is a useful tool for enabling doctors to select activities that are appropriate to their scope of practice. For example, our Fellows are required to consult our competency list when drawing up their professional development plan (PDP) for the year and submit a marked-up copy of this list of competencies if audited. However, we do not believe that it should be a requirement that all activities should be 'mapped' against a curriculum: educational activities typically do not neatly fall into one curriculum outcome area, and 'mapping' would be burdensome and would not necessarily provide information that is relevant to the individual doctor's practice and previous experience. We note that there is a wide variation in the roles undertaken by public health medicine specialists and that these requirements must be considered in determination of individual professional development needs.

1.2 Increased emphasis on evidence, value of activities and peer review

The NZCPHM agrees that recertification programmes should, where possible, be based on activities that have been demonstrated to contribute to learning and that doctors should, where possible, use performance and outcome data and external peer review to identify their professional development needs.

We note that that what constitutes relevant performance and outcome data at the individual level will vary between scopes, and that for public health medicine, it would not be appropriate to use data that relates to individual patients. Peer review is already built into the processes of many of public health medicine outputs currently recognised for recertification purposes, such as academic publication (notably those published in peer reviewed journals), policy development, and media engagement. In other cases, performance and outcome data may not be easy to obtain. We are currently piloting a multisource feedback tool to determine its value as a data source for public health medicine.

1.3 Education and development relevant to workplace and career planning

The NZCPHM supports the principle that education and development should be relevant to the individual doctor's work context and career plan. Recertification programmes should therefore be sufficiently flexible to allow doctors to plan and select activities that will best meet their needs.

1.4 Use of a professional development plan (PDP) to guide learning

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) and has been available since 2004.

1.5 Offering regular practice review

Although there may be value in direct observation of consultation or procedural skills, the NZCPHM is not convinced of the value of a practice review visit for non-clinical practice. Physical visits are costly to undertake, and, in the case of public health medicine, may not result in meaningful observations. We note again the wide variation in the roles (often largely desk-based) undertaken by public health medicine specialists. We believe that MSF may be a better means of review for public health medicine. This approach will be tested when we pilot our new MSF tool in 2019.

If the purpose of the visit is to provide an opportunity to allow the doctor to reflect on their practice with external guidance, there may be other means to achieve this for our scope. For example, our current TOPS requirements include a discussion of the annual professional development plan with a colleague. This process could potentially be strengthened, for example, by periodically including the results of a multisource feedback tool or discussion about longer terms career plans. This activity could be done without the need for costly visits. In addition, we are in the process of establishing a TOPS Advisory Committee whose role will be to provide advice and support to TOPS participants who are having difficulty meeting their TOPS requirements or who wish to discuss issues identified in the MSF process. Other outputs which have peer review and audit built into their processes also provide reassurance and feedback on performance.

In summary, the NZCPHM does not support the requirement for all programmes to offer an RPR. If this is to be required, there would need to be considerable flexibility regarding the form of the review, and how it is conducted.

1.6 Specified CPD hours and type

We understand the document to be saying that the Council will not specify a minimum number of hours per category and agree that it is more appropriate that the colleges set any such minima for their own scopes. We further agree that it is appropriate that the requirements set by colleges for specific types of activities be determined according to the evidence for effectiveness of those activities, where this exists.

Given the general thrust of the evidence referred to in the consultation document, we hope that sufficient flexibility will be given to allow colleges to remove requirements for passive education, in favour of an approach which more strongly emphasises the completion of activities outlined in an individual PDP, informed by college curricula and by the doctor's individual context and career plans.

2. What suggestions do you have about how these key components could be implemented in recertification programmes?

The NZCPHM is not able to comment on how the specific components detailed in the document could be implemented in other scopes. However, we agree with the suggestion implicit in the 'roles and responsibilities' model provided that overall implementation and monitoring should be via the accreditation and reaccreditation process for vocational scopes of practice. In line with those processes, the approach adopted should be formative rather than summative, allowing for the development of programmes over time.

3. Do you foresee any challenges with implementing the proposed approach? What are these and why?

The two areas that will pose the greatest challenge in terms of implementation are the use of performance and outcome data to inform a doctor's professional development, and implementation of an RPR.

Regarding data, the NZCPHM is currently rolling out a pilot of a multisource feedback process which we consider will provide useful evidence to be used by doctors as an input into their annual professional development plans. How effective this will be at identifying areas for development is yet to be determined. The implications of rolling out on a larger scale are also yet to be determined – there is a concern that regular and compulsory administration of the tool may lead to survey fatigue, as the same people will be asked to complete surveys frequently.

In regard to the RPR, see our comments under 7.1.5 above. Any requirement that involves periodic 'visits' to doctors around the country will be costly to implement and the benefits would need to be considerable to justify this cost.

4. Are there any specific implementation concerns for recertification programme providers? Do you have any suggestions about how these issues could be resolved?

Key implementation issues will include:

- finding appropriate tools for providing performance data, if any are required in addition to the new MSF tool which will be introduced in 2019 on a pilot basis
- having sufficient time to pilot and adopt new tools and requirements
- having the time and resources needed to plan for and implement technology system changes
- finding resources needed to implement RPR visits, if this is to be required. If a physical visit is required, the cost of arranging these may be prohibitive.

The NZCPHM works on a very small budget and membership fees are already high. We would not be in a position to implement any solution that required significant funding or membership fee increases.

Any changes to be made would need to fit within our triennium programme timeline: our next triennium begins 1 January 2019, and changes to be made in that triennium have already been approved and are in the system-build phase. The next opportunity to make changes within this cycle is for the triennium beginning 1 January 2022.

5. Do you think there are any recertification activities that should be mandatory for all doctors?

The NZCPHM believes that it is appropriate that medical colleges determine the requirements for the programme under their purview. However, we would support a Council requirement for certain activity categories to be included in all programmes, and would suggest that these be PDP, peer review, cultural competence development, activities aimed at improving health equity, and activities aimed at improving population health.

If the Council wishes to set mandatory requirements for tests of specific learning (such as knowledge of Council regulations and policies), we believe that this should be done outside of college processes.

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 1.5) The NZCPHM is not convinced of the value of a regular practice review visit for non-clinical practice. Considerable flexibility in interpretation of the RPR requirement would be necessary to make this approach relevant to public health medicine.

It is also not clear how much of this process is already taking place as part of employers' annual performance review processes: duplication should be avoided.

7. Other comments or suggestions?

The NZCPHM believes that there are two further core components that could be added to the model proposed.

- Supporting a high level of cultural competence. This requirement would align with the Council's focus on this area and the high level of consensus that this is a critical area to be specified in recertification programmes.
- Supporting a high performing and equitable health system. Activities which contribute to equity, access, system efficiency (and good use of resources), evidence-informed practice, and to improvements in population health should be explicitly valued. A population health perspective is particularly important given the large health implications of threats such as climate change (including the need for emergency response planning) and anti-microbial resistance. These complex threats require doctors to work in more coordinated ways and could be supported by identifying them in recertification programmes.

With regard to the 'roles and responsibilities' model in section 5 of the document, we note that the model is silent on the connection between a recertification programme and the granting of a practicing certificate (PC), which is a Council responsibility linked to satisfactory completion of the

requirements of a recertification programme. Currently Colleges are required to report non-compliance with CPD requirements to the Council and the Council audits the CPD participation of a proportion of all doctors. It would be useful if these roles were included in the model, and the Council indicates whether it anticipates that there will be any changes to this arrangement, or in the information that must be provided by the Colleges to the Council?

We note also that the column under MCNZ responsibilities in the model states that the MCNZ 'sets and reaccredits recertification programmes'. We suggest that this could be better worded as 'sets requirements for and accredits recertification programmes...'

It would be useful for the Council to provide further information regarding the accreditation / re-accreditation standards that will be applied for recertification programmes, and whether it sees these standards as being linked to the principles for recertification (adopted in 2016), or to the core components (outlined in the consultation document).

The NZCPHM believes that a focus on cultural competence and achievement of health equity should be included in all professional development programmes.

We note that this proposal could have made its argument more convincingly by demonstrating the problems it is trying to solve, illustrating these problems by providing examples of where things have gone wrong in the past and providing evidence for the solutions suggested.

The proposal also contains multiple references to the collection and use of robust data. These issues are very much within the scope of public health medicine practice. We consider there may be advantages to the MCNZ in establishing an advisory position within its office for a public health medicine specialist and/or registrar to provide ongoing support for this vital quality assurance work.

We are happy to provide further clarification on any matter covered in this submission.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'F Dumble', with a stylized flourish at the end.

Dr Felicity Dumble
President