17 March 2017

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

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