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Te Kaunihera Rata o Aotearoa I Medical Council of New Zealand

Extension of the provisional vocational assessment period from 18 to 24 months - Consultation under section 14(2) of the Health Practitioners Competence Assurance Act 2003 on one such update - a variation to the prescribed qualification for registration in the Provisional Vocational scope of practice

Tēnā koutou katoa

Te Whare Piki Ora o Māhutonga - Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia. Our mission is to improve access, equity, quality and delivery of surgical care that meets the needs of our diverse communities. The contribution of International Medical Graduates (IMGs) to this mission is invaluable.

We welcome the opportunity to review your proposal to extend the provisional vocational assessment period from 18 to 24 months, enabling a specific cohort of International Medical Graduates (IMGs) who may not otherwise meet the standard to gain provisional vocational registration and complete discrete training to address identified deficiencies in their qualifications, training and experience.

1. Do you support the proposal to extend the assessment period from 18 to 24 months?

We recognise the global and national workforce crisis and the need not to impose unnecessary barriers to IMGs while simultaneously protecting patient safety.

We are aware analysis of previous IMG applications identifies a small specific cohort of IMGs whose qualifications, training and experience may be assessed to be *as satisfactory as* a New Zealand-trained surgeon registered in the same vocational scope of practice if the provisional vocational assessment period is extended from 18 to 24 months and discrete training is provided. We agree it is worthwhile to examine whether extending the provisional vocational assessment period from 18 to 24 months and providing discrete training to address identified deficiencies in the qualifications, training and experience of each IMG would enable more to meet the standard.

We have though a range of concerns about delivery, supervision and assessment of training for IMGs. Our concerns include maintenance of the standard for vocational registration, design and delivery of a suitable training programme, the capacity of the current workforce, and the specific characteristics of RACS nine surgical specialties.

If after consultation MCNZ decides to extend the provisional vocational assessment period from 18 to 24 months for discrete training, RACS will engage with you to ensure that training, employment, supervision, and assessment are robust and safe before being willing to support this extension and introduction of discrete training in RACS nine surgical specialties.

In RACS specialties most IMGs are considered to hold *as satisfactory as* qualifications, training and experience and do not require training. 24 months discrete training will not be necessary or suitable for most IMGs considered to hold qualifications, training and experience *as satisfactory as* that of an Aotearoa vocationally-trained medical practitioner registered in the same vocational scope of practice. It will be appropriate to continue recommending up to 18 months supervised assessment to confirm practice at the standard for vocational registration for the bulk of IMGs.

For clarity we suggest the following small changes below to the wording of the proposal:

> *MCNZ is proposing to extend the **maximum** provisional vocational assessment period from 18 to 24 months. This will enable a specific cohort of IMGs who may not otherwise meet the standard, to gain provisional vocational registration and complete ~~discrete~~ training **in a discrete area of their specialty practice** to address identified deficiencies in their qualifications, training and experience.*

2. Do you see any potential adverse consequences or risks, and if so, how can they be mitigated?

Maintenance of the Standard for Vocational Registration

The Assessment Pathway to Vocational Registration is not currently a training pathway. IMGs considered to hold *as satisfactory as* qualifications, training and experience are required to undertake a provisional vocational assessment period of up to 18 months (with 12 months being the average duration). The Assessment Pathway is to confirm that, in spite of identified differences and deficiencies in training and experience, IMGs in this cohort are practising at the required standard for vocational registration and can apply their skills in the Aotearoa healthcare environment. 18 months is adequate duration for this assessment.

In cases deemed appropriate, 24 months discrete training could be considered for IMGs determined to hold *as satisfactory as* qualifications, training and experience to refresh discrete skills required for practice in Aotearoa that have not recently been practiced, to undertake discrete training in a subspecialty required for practice in Aotearoa, or to remove a proposed exclusion on scope of practice. Assessed supervised consultant level practice is different from training, so training may need to be completed in addition to the average 12 month period of assessed supervised consultant level practice. It may be appropriate to confirm competency in the core common practice within 12 months, with 24 months to confirm competency in a specific low volume surgery. As 24 months is a long time and delivering training is arduous, it may be that some IMGs and their employing hospitals would prefer an exclusion on scope to discrete training.

If an IMG requires more than 18 months to demonstrate competence in the core common practice of a specialty then that IMG's qualifications, training and experience are *neither equivalent to nor as satisfactory as* that of an Aotearoa vocationally-trained medical practitioner registered in the same vocational scope of practice. It would be important for the standard for vocational registration to remain the same. RACS would not be looking at discrete training for those IMGs not practicing at the standard required for vocational registration in the core common practice of a specialty. There are well-established programmes for doctors requiring surgical training. IMGs can register at a more junior level and follow these standard training pathways to obtain vocational registration.

The Structure of Surgical Education and training (SET) and Number of Available Posts

- Surgical Education and Training (SET) in nine specialties is provided by RACS Specialty Boards
- SET is undertaken in posts accredited by RACS Specialty Boards
- FRACS is the standard for SET and for the MCNZ-approved postgraduate qualification for vocational registration
- RACS Specialty Boards and Examinations Court determine whether the standard has been met
- SET is funded by Trainees and Te Whatu Ora

To ensure hospitals and surgical units have the staffing, facilities, case volume, scope, and complexity necessary for SET, those are inspected by RACS. If deemed suitable, SET training posts are accredited. IMGs would receive suitable training if allocated to SET posts in these units.

Potential risks of this approach are:
- IMGs undertaking training may be used to cover call commitments, affecting their chance of successfully completing training
- training of IMGs may detract from the training of SET Trainees
- training posts for IMGs may be hard to find as most are filled by SET Trainees.

In most years all SET posts are filled unless applicants to the SET programme do not meet the minimum standard or a current SET Trainee goes on approved leave e.g. parental, carer's, sick leave. Such leave is taken for an average six months and is not known about far in advance. Consequently, the vacancies available due to approved leave are unlikely to be of adequate duration or appropriate timing for discrete training of IMGs.

For SET Trainees in Plastic and Reconstructive Surgery (PRS) to gain exposure to the breadth of the specialty they move around the country. This would not be practical for IMGs so limited scope may be an appropriate consideration. However, if an IMG does not have exposure (or adequate exposure) to burns, hand trauma, or microsurgery they may not be competent to participate in a general on call roster, which is not acceptable or sustainable for practice in most, if not all, PRS units in Aotearoa.

In some instances, it may be appropriate for IMGs requiring discrete training to undertake such training in a suitable Fellow's Post in a unit with posts accredited for SET. Whether this is appropriate would need to be evaluated case by case.

If MCNZ's expectation is for discrete training to be undertaken in surgical units that do not have posts accredited for SET, this would require an accreditation process for those units. Additional resources would be required by those units for SET Supervisor training, training for Trainers in the unit, protected time for training and assessment, funding for accreditation inspections and Medical Colleges' oversight, review and approval of training. However, in the context of the national workforce crisis and the pressure this puts on service delivery, hospitals that do not have SET accredited posts would be better able to provide service if IMGs not requiring discrete training were employed.

As SET is competency based it would be appropriate for discrete training to be competency based. Consequently, should an IMG not meet required competencies within 24 months a mechanism would be needed to extend the period of assessment by six-month increments. If MCNZ's three year maximum for completion of requirements was reached, provisional vocational registration would be withdrawn.

Capacity of the current workforce to deliver discrete training

It is a significant undertaking to supervise an IMG on the Assessment Pathway to Vocational Registration. The IMGs, their supervisors, and units seldom receive rostered time to undertake supervision or assessment. It is hard to find willing and able Supervisors. Given the limited pool of Supervisors, recently registered IMGs are being tasked with supervising and assessing IMGs even newer to Aotearoa. For these reasons and more (e.g. size of unit and colleagues available for support) supervision of IMGs varies across surgical units.

For the current IMG cohort 18 months (12 months being the average) is adequate to observe technical and professional skills, to assess a wide range of cases and scenarios, and for acclimation to occur before final judgement on competence. It will be important not to conflate extended supervised assessment with discrete training.

The proposed new cohort of IMGs about which there will be less certainty regarding qualifications, training, and experience will not only need greater supervision and assessment due to their potentially more variable levels of practice, but also training. Discrete training will take longer, require more from (and thus place more burden on) Supervisors and surgical units than is currently the case. This may necessitate mechanisms (e.g. protected rostered time) to compensate for the time and effort required of those in the surgical units training these IMGs, as well as acceptance from the employing hospitals there may be decreases in efficiency and clinical productivity.

Assessment of training is by consensus of a surgical unit, with varied input into and moderation of the assessment. Supervisors and colleagues in a unit (referred to as 'Trainers' by RACS) would need to have a nuanced understanding of the standards, scope of practice, assessment tools etc. required to provide discrete training to IMGs. To gain this understanding, orientation and training would be required.

Mentorship is about knowledge, support, feedback and connections. Supervision is about observing and ensuring practice is appropriate. There is an inherent conflict between mentorship of IMGs and supervised assessment. Ideally all IMGs (not only those completing discrete training) would have both a Mentor for support and a Supervisor for oversight and assessment.

Successful introduction of discrete training would require a shared understanding between MCNZ and RACS of the various roles required and orientation for surgeons in those roles to deliver that training.

Specific characteristics of RACS nine surgical specialties

Discrete training might not be appropriate for the scopes of General Surgery, Otolaryngology Head & Neck Surgery, and Cardiothoracic Surgery. In Cardiothoracic Surgery specific deficiencies would be hard to conceptualise. Possibly the most common situation for this specialty would be an IMG with cardiac training but only minimal thoracic training or practice prior to moving to Aotearoa. In such situations it might either be appropriate (depending on the specifics) to recommend vocational scope with a limitation to cardiac practice or further formal training through SET if the IMG wished to attain full unrestricted registration across the scope of Cardiothoracic Surgery.

3. Do you have any other comments regarding the proposal?

The MCNZ Workforce Survey 2024 indicates, “Most IMGs who register in New Zealand do not stay for long periods. Just over 40 percent leave after one year, 60 percent after two years, and 75 percent after 10 years.”

It is unknown whether the introduction of two years discrete training would positively or negatively impact the retention of those 60 percent of IMGs who leave after two years. Consideration of the potential impact of discrete training on IMG retention is recommended.

Nāku noa, nā

Ros Pochin
Chair, Aotearoa New Zealand National Committee

RACS represents more than 8300 surgeons and 1300 surgical trainees and IMGs in nine surgical specialties across Aotearoa New Zealand and Australia. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research.