MEDICAL COUNCIL NEWS

Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

Chairperson's foreword

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> "It is in education and performance, areas that are absolutely core to fitness for practice, where there is scope for improvement and certainty of change.....

The Medical Council's principal purpose is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise" (Health Practitioners Competence Assurance Act 2003 (HPCAA)).

The Council's mechanisms for ensuring safety in the areas of registration and health are well established and tested. Over the last few years, we have made several changes to the registration pathways. These new pathways and assessments are working effectively and will be further refined rather than undergoing major change in the immediate future.

It is in education and performance, areas that are absolutely core to fitness for practice, where there is scope for improvement and certainty of change.

The Council uses a range of mechanisms to ensure quality in education and performance. These include:

- the accreditation of the medical schools and postgraduate colleges. Accreditation is

"We need improved continuity between the undergraduate and postgraduate years with reinforcement of the scientific basis of medicine as preparation for vocational training....

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carried out in partnership with the Australian Medical Council and, in New Zealand, includes the accreditation of the colleges' continuing professional development programmes (CPD)

- the setting of specific CPD requirements including peer review and audit
- the accreditation of hospitals for the intern year, the appointment of intern supervisors and regular reporting on interns
- random reviews of 10 percent of doctors to ensure they are meeting their CPD requirements
- performance reviews when concerns about competence are raised
- the supervision of doctors new to the country.

These measures alone are not sufficient to ensure fitness to practise and our systems for ensuring quality have some important gaps. There are areas of training and practice that need to be addressed if the Council is to meet its obligations under the HPCAA. These include:

i) **the experience gained in the intern year and the years between completion of the intern year and the commencement of vocational training**

These have been called the "transitional years", but this term is inadequate because it understates the educational and service importance of these years. The time between undergraduate and postgraduate work is not simply a bridging period. It is a critical educational period during which the graduate gains the experience needed for registration within a general scope of practice and lays the foundation for vocational training. It should be a period in which the graduate acquires specified competencies and works with lots of patients, colleagues and other health professionals in a variety of clinical settings. This period has three equally important components: experience, education, service.

Council wishes to see greater investment in education in these years with graduates having work experience in primary care and also setting and achieving specific competencies. We need improved continuity between the undergraduate and postgraduate years with reinforcement of the scientific basis of medicine as preparation for vocational training.

Experience gained through completing a working attachment in primary care is important not only for those considering a career in general practice, but also for those whose careers will be hospital based. Some understanding of community care is gained in the current undergraduate programmes, but postgraduate work is needed to build on this understanding.

The Council surveyed a wide range of parties on the possible introduction of a required postgraduate attachment in general practice before achieving general scope. We found strong support

in theory for such an attachment, but concern about capacity and our ability to develop the necessary resources.

It is imperative that the educational components of this period are improved. We have been talking about this for 20 years and have achieved little – some would maintain we have gone backwards. If this period during which registration within a general scope of practice is achieved and the foundations for vocational training are laid is to improve, then we must start planning and investing now.

Improvement will require designated funding over a minimum period of ten years and cooperative planning by all the key players. The Council has formed a joint working committee with the Medical Training Board and is in discussion with other parties. **Intern supervisors and senior doctors are critical to these developments and their contributions need appropriate recognition.**

We cannot increase experience in general practice unless investment continues in infrastructure, buildings, equipment and staffing. Practices with the capacity to accommodate and train registrars, undergraduates and graduates in their first two years do not arise overnight. The physical resources need to be funded and developed over the next decade with incentives for general practitioners to be part of the process.

There is much talk of quality. Quality cannot be achieved if the foundations of clinical practice are not sound. Why would we not invest in these foundation years?

ii) **the lack of ongoing practice assessment as a means by which doctors identify any deficiencies in their practice and are assured of their ongoing fitness for practice**

I anticipate that in the next five to ten years we will see universal regular practice reviews by colleagues as an accepted part of clinical practice. The Royal Australasian College of Obstetricians and Gynaecologists in New Zealand and the New Zealand Orthopaedic Association are leading developments in this area. The Royal New Zealand College of General Practitioners has years of experience in practice reviews. In my discussions with a wide range of professional groups, I sense a willingness to introduce such reviews.

Completing CPD requirements is necessary for recertification. However, totting up points for educational activities provides little assurance of ongoing fitness for practice. Some components of CPD, such as peer review and audit, if carried out in a rigorous way, do provide some assurance of competence. Council is developing more specific requirements for peer review.

Practice reviews provide a much more direct assessment of professional performance and a guide to areas of strength and weakness. The introduction of practice reviews will need to be a staged process. It must be of value to the practice of the more than 95 percent of New Zealand doctors who are competent and have spent a lifetime of practice trying to be even better. Any deficiencies identified will be best handled at the college, association or educational provider level. The Council would only need to be involved if there were unresolved problems and concerns about patient safety.

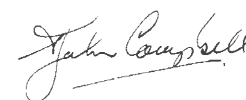
Several bodies may develop practice review programmes; however, a doctor would obviously have only one review. The review may be part of CPD or part of a credentialing exercise. The methodology needs to be sound and consistent. Council and several colleges have the experience to develop a reliable and valid system.

Even if done only every five years, two doctors reviewing the practice of a colleague for a day will be an expensive exercise. Currently those doctors undergoing performance reviews as part of their CPD are meeting the costs themselves. If we are to introduce practice reviews across the profession – and it is most important for public confidence and safety that we do – then Vote Health funding will be needed.

Public discussion about quality

With the release of the Quality Improvement Committee report on sentinel events, and some recent reports from the Health and Disability Commissioner, there has been considerable public discussion about quality in the health system. An essential requirement for quality is a well-trained and well-maintained medical workforce, which requires investment not only in the undergraduate years and in vocational training, but also in the years immediately after graduation and in the years of continuing practice.

It is time for a planned, substantial investment in the quality of health care in New Zealand. Such an investment is essential if we are to assure the public that all doctors are fit to practise.



John Campbell
Chairperson

If you would like to comment on anything raised in this article, please contact Professor John Campbell, Council chairperson, by email at jcampbell@mcnz.org.nz

Viewpoint – The Medical Training Board by Len Cook, Chair

Establishment of the Medical Training Board

The concept of a Medical Training Board has been around for many years, although no board was established until late in 2007, the first meeting taking place in November 2007. The terms of reference and broader focus of activities of the board were developed from the 2007 Workforce Taskforce report chaired by Dr Robert Logan, whose findings were accepted in full by the Ministers of Health and Tertiary Education. The board has set out to deliver on these recommendations.

Leadership and governance

The major providers of medical education and training all have a high degree of autonomy, and the Medical Training Board has responsibility for bringing leadership and governance to the whole system of medical training. While those involved in medical education and training have strong networks across parts of the training system, there has been little focus on bringing collective leadership to the system as a whole. The Director-General of Health and the Chief Executive of the Tertiary Education Commission or their representatives attend the board in an advisory capacity. The board is drawing on work done in the Ministry of Health (including the Clinical Training Agency), and among the DHBs, the Medical Council, universities, medical colleges and other organisations.

Making a start

The board has been somewhat hampered by the way the understanding of our health training system is inadequately informed by robust statistics and research, and because so many of the measures we have are not easily available. The common understanding on which we should base effective decisions about such a complex system as medical training is likely to be limited, and the decisions of most of those involved in medical training will draw mainly on their own world view.

For example, training is not included in the performance measures of DHBs, although perhaps nearly 30 percent of hours of medical graduates in the health service involve receiving or giving training. **One valuable contribution of the Medical Training Board would be to bring some coherence to what we might anticipate to be the nature of the health system in some 20 years time,** where that sets the context for health education and training in the near future. From the brief set for the board by the two Ministers, we recognise right now we have two priorities:

- the medical training continuum
- accurate forecasting for medical training.

The medical training continuum as a priority

The need for an integrated training system has been recognised by almost all those considering medical education and training. While ideally this integration needs to extend from first enrolment at university through to retirement, it is evident that the area that needs greatest attention is the period between the last year at medical school and entry into vocational training.

Defining the establishment of clear expectations and obligations for the training continuum up to point of entry to vocational programmes is therefore very important. By the end of June 2008, we will have produced a draft specification to establish a curriculum, outcomes and assessment methods for each year of clinical training up to entry into a college programme.

We expect to identify changes in other parts of the health service that will be necessary so that our proposals may have a genuine chance of success, given the complexity of our health service and the interdependencies and interactions that any change brings. We are collaborating on this task with groups of medical educators. We are also working with the Medical Council, while being fully cognisant of their statutory roles in this area. We have now met most of the medical colleges to begin discussions with them about the training continuum, and we expect further engagement to build on these initial meetings. Our proposals for a curriculum, outcomes and assessment

methods will be distributed for widespread consultation.

Forecasting the level of medical training – getting the numbers right at entry level and beyond

These discussions also inform our second priority, which is to establish a better way of estimating the numbers and types of doctors we need to train over the next three decades. When we look ahead some two or three decades, we know a lot about the future increase in the New Zealand population, and the shift in the composition of the population through ageing. There is much uncertainty about the effect of technological and other change, and little common ground as to what our health service might look like, and the way professional roles will evolve over this time.

Given that next year's intake of first-year medical students should expect to complete a vocational training programme around 2024–25, we cannot ignore the impact of this sort of change on the role and nature of training. To this end, the board is well through building up an understanding of the uncertainty that we will always have about many of the long-term influences on training, and the way in which this uncertainty should shape our forecasts. This information will build on knowledge gained from the medical colleges, DHBs and others who have to make assumptions about future supply and demand.

One significant uncertainty will always be the long-term level of resources that can be put into health in New Zealand, given the high opportunity cost in terms of reduced education, retirement provision and other public investment, unless we become richer as a nation. We therefore have to plan to be able to balance supply and demand, whatever this level may be.

> "There has been a clear need for some time to have a greater share of clinical training taking place in general practice...."

Drawing on overseas experience

The Medical Training Board aims to be quite comprehensive in its assessment of the influences on future medical trainee numbers, and its preferred scenarios and assumptions will be able to be readily challenged as they evolve. The recent experiences in medical training in the United Kingdom highlight the significance of well-founded judgement about what the future level of medical trainees needs to be. The impact of rapidly increasing then halting growth in a complex system has had many unintended side effects. This calls for greater long-term stability in change processes. The UK experience has also highlighted the critical nature of the understanding and commitment of all parties to new processes, and the need to continually oversee the way changes are being implemented.

Some more immediate responses

The current concerns about the medical workforce highlights that even a rapid rise in the number of entrants to our medical schools cannot influence the supply of doctors for about a decade. Some agreed initiatives are put in place too slowly, and we think that some of these concerns could be more immediately responded to by other changes in the health service. These changes will be discussed in the June report of the Medical Training Board.

Past reports on medical training have reached the following conclusions:

- The development of the medical training system needs to become part of the policy performance targets that drive initiatives in the health service.
- There has been a clear need for some time to have a greater share of clinical training taking place in general practice. The establishment of a strong clinical training capability for general practice in community settings may need to become a more prominent goal of the Primary Health Care Strategy.
- The post of clinical training director now exists, but in only two district health boards. There may be a great benefit in giving a higher priority on putting these roles around New Zealand.

These examples indicate the breadth of issues that the Medical Training Board will need to address in a cohesive manner if proposals focused on improving the management of the medical training continuum are to be successfully put in place in a reasonable time.

Your contributions are welcome

The Medical Training Board is making its preliminary thinking available on its website **www.moh.govt.nz/medical training board**. Your reflections and information would be most welcome.

Len Cook
Chair Medical Training Board

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Members of the **Medical Training Board**

Mr Len Cook – Chair

NZ Government Statistician from 1992 to 2000, National Statistician United Kingdom from 2000 to 2005.

Visiting Professor in the Department of Epidemiology and Public Health at University College London, and Research Associate of Population Studies Centre at Waikato University.

Dr Stephen Child

A member of the Royal Australasian College of Physicians and Director of Clinical Training at the Auckland District Health Board.

Dr Kenneth Clark

A member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Chief Medical Officer at MidCentral District Health Board.

Dr Malcolm Futter

An anaesthetist and the Interim Director of the Capital and Coast District Health Board's Anaesthesia, Intensive Care and Pain Medicine.

Dr Sue Hancock

A member of the Royal New Zealand College of General Practitioners and a general practitioner at the Royal Heights Medical Centre, Massey, with previous experience in rural health.

Professor Iain Martin

Dean of the Faculty of Health Sciences at the University of Auckland.

Mr David Meates

Chief Executive of the Wairarapa District Health Board and Chair of District Health Boards New Zealand's Medical Workforce Strategy Group.

Associate Professor Papaarangi Reid

Tumuaki (Maori Dean), Faculty of Medicine and Health Sciences at the University of Auckland

Professor Don Roberton

Pro Vice Chancellor, Division of Health Sciences and Dean, Faculty of Medicine, at the University of Otago

Dr Cindy Towns

A doctor in training with recent involvement with the New Zealand Medical Students Association

The Director-General of Health and the Chief Executive of the Tertiary Education Commission are Special Advisors to the Medical Training Board.

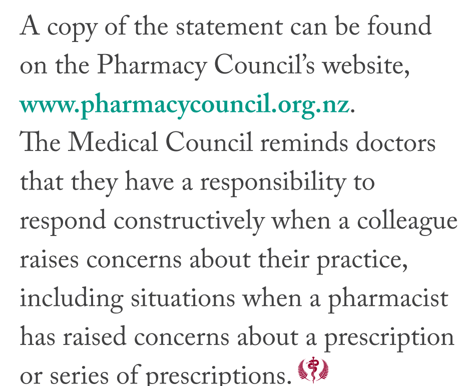
Pharmacists raising concerns with prescribers

The Pharmacy Council has recently published a statement giving guidance to pharmacists in determining when, why and how concerns should be raised with prescribers.

The Pharmacy Council stated that it has fielded calls from pharmacists requesting advice on the process to follow when they have concerns about recurrent, inappropriate prescribing. Coupled with these queries, an investigation into a complaint to the Health and Disability Commissioner found that through a combination of errors both a doctor and a pharmacist had breached the Code of Health and Disability Services Consumers' Rights.

The Commissioner's comments made it clear that pharmacists have a responsibility to raise concerns about a doctor's practice, whether due to a specific prescription or recurrent inappropriate prescribing.

A copy of the statement can be found on the Pharmacy Council's website, **www.pharmacycouncil.org.nz**.



The Medical Council reminds doctors that they have a responsibility to respond constructively when a colleague raises concerns about their practice, including situations when a pharmacist has raised concerns about a prescription or series of prescriptions.

The New Zealand Medical Workforce in 2006 – workforce survey results

In March 2008, the Council released the results of its workforce survey in the publication *The New Zealand Medical Workforce in 2006*.

During the 2006 survey, 11,662 survey forms were sent out to doctors with New Zealand addresses and an annual practising certificate. Of those, 10,035 doctors responded giving a response rate of 86 percent. The survey results include only the 9,547 doctors in "active employment" working four or more hours each week.

Key facts from the survey follow.

- Using registration data to estimate the annual growth in the number of active doctors shows an increase in the active workforce of 6.1 percent from 2005 to 2006.
- The proportion of women doctors increased to 37 percent of the total workforce; 57 percent of house officers; 43 percent of general practitioners (GPs); and 32 percent of specialists including GPs. Women made up 24 percent of hospital specialists.
- The proportion of international medical graduates (IMGs) rose by just under 3 percent to 40 percent of the workforce. IMGs made up 31 percent of house officers, 41 percent of GPs, and 40 percent of specialists including GPs.

> "The proportion of international medical graduates (IMGs) rose by just under 3 percent to 40 percent of the workforce"

These increases may result from the change to the sampling frame of the questionnaire. So rather than representing an increase, the 2006 figures are likely to be a more accurate picture of the role of IMGs in the medical workforce.

- IMGs made up 50 percent of doctors working in accident and medical practice, family planning and reproductive health, neurosurgery, palliative medicine, psychiatry, radiation oncology, and rehabilitation medicine.
- The increase in the proportion of IMGs was most notable in accident and medical practice (from 50 percent to 64 percent), emergency medicine (35 percent to 47 percent), musculoskeletal medicine (29 percent to 40 percent) and vascular surgery (25 percent to 43 percent).

There were also notable decreases in the proportion of IMGs in medical administration (55 percent down to 38 percent) and rehabilitation medicine (71 percent down to 60 percent).

- The proportion of Māori doctors was 2.5 percent (240 doctors) in 2006 and 2.6 percent in 2005. The proportion of Pacific Island doctors was 1.6 percent (155 doctors) in 2006 and 1.5 percent in 2005.

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Both these groups continue to be markedly underrepresented compared to their proportion in the population. The 2006 census indicates that 14.6 percent of New Zealand residents identify as Māori and 6.9 percent identify as Pacific Island people.

- The workforce survey showed that GP numbers increased by 6.2 percent and are now beginning to approach the year 2000 figure of 3,166.
- Medical officer numbers continue to increase steadily and are up 18.8 percent since 2002. Only 17 percent of medical officers reported being in vocational training, and 84 percent listed "public hospital" as their main workplace.
- Forty-one percent of medical officer hours were spent in emergency medicine or psychiatry. The next largest work type was internal medicine (12.5 percent).
- Fifty-nine percent of medical officers were IMGs and 44 percent were women.
- All vocational trainees in breast medicine, family planning and reproductive health, and sexual health medicine were women. Women also outnumbered men in training in obstetrics and gynaecology (63 percent), paediatrics (72 percent), palliative medicine (63 percent), pathology (61 percent), public health medicine (78 percent), radiation oncology (73 percent) and otolaryngology, head and neck surgery (56 percent).
- Vocational scopes where women outnumbered men were breast medicine and sexual health medicine. All doctors working in breast medicine were women. In sexual health medicine, 83 percent of doctors were women.

Retention of New Zealand doctors

A review of graduate retention statistics since the introduction of the Medical Practitioners Act in 1995 continues to show that by the third year after graduation about 25 percent of doctors are not practising in New Zealand.

On average, 81.9 percent of graduates are retained by the second year after graduation, dropping to 74.2 percent by year 3.

After year 3, the retention average increases slightly in years 4 and 5, and then slowly decreases again through years 6 to 11.

There is little variance in the percentage of registered graduates retained in any given postgraduate year across the class years analysed.

> "There is little variance in the percentage of registered graduates retained in any given postgraduate year across the class years analysed...."

No firm statistics exist about what medical graduates do if they do not register to do their intern year in New Zealand. Figures do include fee-paying students, and the initial drop in retention may possibly be caused by these graduates returning to their sponsoring countries. Others do their internship overseas, and some have the year off.

The Council does not collect information about doctors no longer practising in New Zealand. They may be practising overseas, or not practising at all. Some doctors leave New Zealand to gain postgraduate qualifications and then return some years later.

Retention of international medical graduates

Less than 50 percent of IMGs are retained in the year immediately after initial registration. This trend has been consistent across the period analysed, with little variance in the proportion retained.

After this initial drop, the percentage of IMGs retained continues to reduce gradually, dropping to just under 33 percent in the third year after initial registration.

Doctors from Asian countries have the highest retention rate, followed by South African doctors and then European doctors.

More than 50 percent of doctors from Asian countries are retained even six years after registration. The retention rate of South African doctors drops below 50 percent only after five years.

Doctors from the United States and Canada have the lowest retention rate, with less than 30 percent at one year after registration and less than 10 percent as early as four years after registration.

Doctors from the United Kingdom also have lower-than-average retention rates. Fewer than 30 percent of these doctors are retained 2 years after registration, and the rate drops below 20 percent after 6 years.

These figures suggest that doctors from North America and the United Kingdom are more likely to come to New Zealand to work for a limited period than doctors from Asia, South Africa and Europe.

A copy of the full report can be found at **www.mcnz.org.nz** >>Publications>>Statistics.

Helping us help you – annual practising certificates

This year, the Council will issue more than 13,000 annual practising certificates (APCs).

Applying for your annual practising certificate

Before posting your application, please make sure that you:

- complete all sections of the application form
- include payment of the fee
- include certified documentation confirming your change of name (if relevant)
- arrange for certificates of good standing to be sent direct to Council if you have worked overseas
- ensure that your colleague, supervisor or the supervisor of training has signed section 4
- include any documents relating to section 7.

Most doctors return correctly completed APC applications to us. However, errors or oversights in an application are time-consuming for Council staff to follow up and will delay the issuing of your APC.

Keeping your APC up to date

Applications are sent out six weeks before expiry date. Please complete the APC application form and return it to us by the 15th of the same month your APC expires. You should allow 20 working days for us to process your application. Your new APC will not be backdated if your application form arrives in the Council office after your current APC expires.

The HPCAA states that a doctor is considered to hold an APC from the date the fully completed application and fee is received in the Council office until the date the certificate is issued, or until the doctor is advised that the APC will not be issued for some reason.

Monitoring changes in the workforce

The APC application form has a workforce survey attached. Data collected on the survey plays a critical part in helping the Council and other stakeholders to monitor changes in the workforce.

We have taken responsibility for collecting information on medical practice each year. As well as providing workforce statistics to the Ministry of Health, the Council also assists individual researchers and special interest groups. Your cooperation in completing the workforce survey is essential – a high response rate and accurate reporting are important as policy decisions are based on the data provided.

The 2006 workforce survey had a response rate of 86 percent. We would like this figure to be higher and the statistics to be truly representative of the profession.

Keeping the workforce database confidential

Council owns the medical workforce database and vigorously protects its confidentiality. We do not release unit data to the Ministry of Health. To prevent possible identification of individual doctors, we do not publish any information derived from the survey where results show figures less than four.

Find out more

More information on completing your APC application can be found at www.mcnz.org.nz >>publications>>medical registration.

Good medical practice updated

The Council has reviewed and updated its key resource *Good medical practice*. We've enclosed a copy of the new edition. This booklet sets out the Council's expectations of best practice by the medical profession.

The revised *Good medical practice* is easier to follow as a result of more direct and focused language and the use of sidebars linking the resource to other Council statements and resources.

Setting standards for professional conduct

The Council expects all doctors to be familiar with *Good medical practice* and to follow the guidance it contains. Doctors should be aware that the Health Practitioners' Disciplinary Tribunal, the Council's Professional Conduct Committees and the Health and Disability Commissioner may use *Good medical practice* as a standard by which to measure their professional conduct.

Summary of changes

Key changes to *Good medical practice* are:

- We expect that all staff for whom you are responsible and who require supervision, including locums, junior colleagues and international medical graduates (IMGs) who are new to practice in New Zealand are properly supervised.
- We acknowledge that, if doctors delegate care to a colleague, they are not responsible for the decisions and actions of that colleague; however, they remain responsible for their decision to delegate and for the overall management of the patient.
- We expect doctors to be aware of cultural diversity and to act effectively and respectfully when working with and treating people of all cultural backgrounds.
- We expect that a patient whose care is in the process of being transferred between a doctor and another health-care provider remains under the care of one of the two at all times. In addition, formal handover is essential and the higher the degree of activity, the more important it is to ensure appropriate communication at the point of transfer. The chain of responsibility should be clear throughout the transfer.
- We expect that doctors will behave at all times in a way that justifies their patients' trust in them and the public's trust in the profession.
- We clarify the requirement that doctors inform the Council without delay if, anywhere in the world, they have been charged with, or found guilty of, a criminal offence; or if another professional body has made a finding against their registration as a result of "fitness to practise" proceedings.

Updated Council statements

Several of the Council's statements are being updated to make sure that references to *Good medical practice* are appropriate. Copies of revised statements can be obtained by:

- emailing mcnz@mcnz.org.nz
- downloading the statements from www.mcnz.org.nz>>publications.

Order your free folder

In recent years, the Council has produced over 30 statements on topics such as:

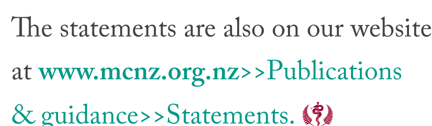
- informed consent
- the responsibilities of doctors in management positions
- keeping patient records.

You can order a free hardcover folder to store these statements.

We encourage you to order a folder for yourself or your practice. As new statements are produced, or others are updated, we will send them to you automatically with the Council newsletter. You can then file them in the folder for quick reference.

You can place your order at folder@mcnz.org.nz or phone 0800 286-801 extn 793.

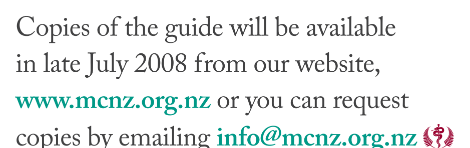
The statements are also on our website at www.mcnz.org.nz>>Publications & guidance>>Statements.



A guide to cosmetic procedures for patients

The Council is producing a *Patient's guide to cosmetic procedures* written in plain English. The guide has been written for patients who are considering a cosmetic procedure. It outlines issues patients should be aware of and questions they should ask their doctor.

Copies of the guide will be available in late July 2008 from our website, www.mcnz.org.nz or you can request copies by emailing info@mcnz.org.nz



Under the microscope

Last year, we commissioned TNS Conversa to conduct research with key stakeholders and the profession. The purpose of the research was to find out:

- what understanding key stakeholders, the public and the profession have of the role and function of the Council
- whether the Council's communications (through publications and media comments) are clearly understood and effective.

The research looked specifically at:

- understanding of the Council's role
- overall satisfaction with the Council's performance
- satisfaction with specific performance attributes (and reasons for dissatisfaction)
- awareness of, and use made of, Council communications and resources
- satisfaction with the Council's website.

Doctors took part in 562 interviews online between 28 August and 14 September 2007.

The research included online interviews with 506 health consumers using a random sample representative of the community from the Smile City online panel.

In total, 14 stakeholders were interviewed, including four journalists and four representatives of medical colleges. The balance included medical groups, doctors' groups, and advocacy and consumer groups. As well, 14 other doctors were interviewed.

All names of the individuals and organisations who took part in the research were kept confidential.

Summary of the results of the research

Role of the Council

Doctors were asked to define the role of the Council. From their responses, the Council's role is most closely associated with registration, regulation of the profession and protection of public safety, in that order.

Interestingly, some doctors perceive the Council as representing the interests of the public to the exclusion of those of the profession. Generally, however, doctors have a good understanding of the Council's role.

Performance of the Council

Doctors were asked how satisfied they were with the Council's performance. The Council scored an average of 4.7 out of 7 (where 7 means "very satisfied"). This score shows that, while most doctors positively assess the Council's performance, many are ambivalent or undecided. The Council therefore has room to improve the profession's perception of its performance.

Performance scores are relatively consistent across subgroups.

Performance attributes

Doctors were asked to rate their agreement with statements describing various aspects of the Council's service and activities (attributes).

The attribute for which the Council scored the highest in terms of performance was "Doing a good job protecting public safety".

Drivers of satisfaction

Analysis shows that 6 of the 12 statements drive over half of overall satisfaction. The most important attributes are:

- "The Council has a clear understanding of the profession"
- "The Council is accessible"
- "The Council is responsive"
- "The Council does a good job protecting public safety".

Further analysis shows that while "The Council has a clear understanding

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of the profession" and "The Council is responsive" are among the most important drivers of satisfaction, doctors rank the Council's actual performance as below average on these statements.

More positively, doctors rate the attributes "The Council is accessible" and "The Council does a good job protecting public safety" as above average.

The Council's website

Doctors were asked about their awareness of, and satisfaction with, the Council's website and its content.

Nine out of ten doctors report being aware of the Council's website, and seven out of ten report having visited it. Awareness of a section of the website is linked to satisfaction – the more well known the section, the higher the satisfaction. The most well-known / satisfying sections are:

- Registration.
- Publications.

The Council scores 4.9 out of 7 for overall satisfaction with the website. Satisfaction is largely consistent across all subgroups, but doctors registered in a vocational scope are significantly more satisfied than other doctors.

Medical Council News

Doctors were asked if they read *Medical Council News*. Eighty-three percent of doctors report reading *Medical Council News* – a very positive result overall. Readership is even higher among GPs and practice-based doctors.

Public comments

Doctors were asked their satisfaction with public comments made by the Council over the past 12 months. The Council scores 4.9 out of 7 for satisfaction with public comments. Again, there is evidence of some ambivalence.

Doctors who are more likely to be satisfied with public comments made by the Council are:

- those working in general practice (but not GPs necessarily)
- those who are not trainees
- doctors who work somewhere other than a practice or hospital.

Using the research results to improve our performance

Both doctors and consumers have good understanding of the different roles the Council plays, but for both groups, the profile of protecting public safety could be increased.

One of the main issues the Council needs to manage is the tension between the perception of, or desire for, a Council that advocates on behalf of doctors, and the perception that the Council operates solely on behalf of patients. Clearly articulating the Council's position will go a long way towards managing the expectations of both doctors and the public.

The survey results show that while many consumers have an adequate knowledge of the Council's role, there is room to improve the perception of the Council as a protector of public safety. Many consumers (18 percent) still thought the Council heard or resolved complaints, with just 1 percent indicating Council's role was protecting public safety.

We are looking at ways of letting consumers know that complaints should go directly to the Health and Disability Commissioner.

Strong level of trust in doctors

The good news is that trust at a personal level is strong between health consumers and their doctor. The challenge is to extend this level of trust to the broader profession (especially IMGs). Analysing the data shows that the length of time a consumer has been with a regular doctor influences their level of trust of their own doctor and of the profession as a whole.

Last year, the Council held a media day that focused on the value international medical graduates add to our health-care system. In the coming months, we will be doing more work in this area.

Several doctors and stakeholders discussed the issue of the Council election and how the make-up of the Council is determined.

> "The good news is that trust at a personal level is strong between health consumers and their doctor. "

We have since had discussions with the Minister of Health and we are making good progress.

Copies of the research are available on our website, www.mcnz.org.nz.

We would like to thank all those doctors who took the time to participate in our survey and share their thoughts with us.

If you would like to comment on anything raised in this article, please contact Philip Pigou, the Council's chief executive, by email at ppigou@mcnz.org.nz

The Council's registration processes

The registration team's core business is the registration of doctors. The team's functions are outlined below.

Registration of doctors

The registration process is straightforward for graduates of New Zealand and Australian medical schools. By contrast, the process is much more comprehensive and robust for international medical graduates (IMGs) applying through various pathways for registration within a provisional general scope of practice. This is because Council, in addition to determining if the applicant is fit and competent to practise within a prescribed scope of practice, must also determine that an overseas qualification is 'equivalent to' or 'as satisfactory as' that of a New Zealand graduate.

The team also deals with vocational scope applications from:

- those who have gained the prescribed Australasian postgraduate qualification
- IMGs who wish to gain permanent registration in New Zealand to work as specialists.

Doctors working under supervision

New Zealand and Australian graduates, and those doctors who have sat and passed NZREX Clinical, work for a minimum of 12 months under the supervision of Council-appointed intern supervisors. These supervisors work closely with registration staff if any concerns are identified about the doctor's performance during their initial period of registration.

IMGs work under supervision for 12 to 24 months. Council-approved supervisors provide performance reports to Council every three months. Registration staff are the first point of contact for supervisors who may wish to raise concerns about a doctor's performance.

Applications for a change in scope or conditions

Doctors registered within a provisional general or provisional vocational scope of practice work in a position approved by Council under the supervision of a supervisor approved by Council. They must make an application each time they wish to change employment or supervision arrangements.

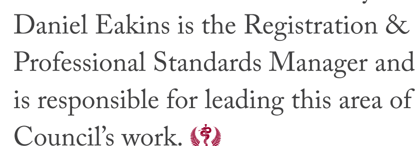
The team also deals with applications from doctors who have met the requirements to move from a provisional to a general or vocational scope of practice, or wish to have any conditions or limitations on their scope of practice removed.

Processing applications for annual practising certificates (APC)

The APC team processes and sends out about 3,000 applications each quarter and audits 10 percent of the APCs to evaluate how well doctors are meeting recertification requirements.

The team also consider applications for APCs from doctors who have not practised recently or who are returning from practising overseas.

The team is part of a larger team which includes the Professional Standards area that handles any concerns related to performance or conduct. It is also involved in setting standards for medical education in the country. Daniel Eakins is the Registration & Professional Standards Manager and is responsible for leading this area of Council's work.



'Lost' doctors

The following doctors will be removed from the medical register unless we receive their new addresses. If you know how to contact these doctors, please email **apc@mcnz.org.nz** or phone 0800 286-801 extn 785.

- Dr Vanessa Helen Jeanne Barkey
- Dr Joy Krishna Chakraborty
- Dr Roy William Fischer
- Dr Lawrence Hyun Chul Kim
- Dr Margaret Ann Legge
- Dr Maya MacFarlane
- Dr Wagdi William Nagib
- Dr Benjamin James O'Leary
- Dr Sashendra Senthi
- Dr Perry Charles Turner
- Dr Deborah Marie Whalley
- Dr Guy Anthony Wright

Ethics 101 – a new column on ethical issues facing the profession

Do you know when it's inappropriate to accept a gift from a patient? What do you do if you hear that one of your colleagues is limiting patients to one medical complaint for each visit? Can you refuse to accept a new patient if they have a complex medical history?

When faced with these types of dilemmas, doctors often contact the Council for guidance. Unfortunately, the response isn't always black and white. The details of each individual situation tend to be unique so the advice we give to one doctor may not be the same as that we give to another doctor in what appears to be a similar situation.

Encouraging dialogue on ethical issues

To encourage dialogue on these issues, the Council has introduced a new column for *Medical Council News* called 'Ethics 101' – inspired by a column published by the College of Physicians and Surgeons of Alberta.

In each newsletter we'll outline an ethical issue and ask for opinions from the profession. We'll publish a selection of answers giving various viewpoints in the next *Medical Council News*. We'll also publish the answers on our website.

There will be no right or wrong answers – rather we aim to hold a thoughtful discussion about the pros and cons of various approaches. The discussion will allow doctors to benefit from colleagues' ideas. We hope it will create interest and generate further discussion among the profession about practical ethical issues.

What would you do?

You have enjoyed working in general practice for ten years but have recently received an offer to join a new cosmetic practice.

The hours, pay and working conditions would be much better than you currently enjoy, but you are acutely aware that there is a shortage of general practitioners in the area. And, you know your patients will have difficulty finding a new doctor.

Do you have an obligation to the community to continue providing care? Or should you accept the offer, which will allow you to work less for significantly more income?

Send us your ideas

Email your answers to Michael Thorn at **mthorn@mcnz.org.nz**. (Use the subject line "Ethics 101".) If you have ideas for topics for future columns, please feel free to send them to us as well.

Keeping in touch

The Health Practitioners Competence Assurance Act 2003 (HPCAA) requires that doctors provide the Council with their postal, residential and workplace addresses. A residential address cannot be a post office box number or a worksite.

One of these addresses has to be nominated as a registered address to be placed on the medical register. Your registered address is the only address available to the public.

Keeping your registered address confidential

If you do not want your registered address to be publicly available, you can ask for it to be kept confidential by writing to the Registrar.

The HPCAA also requires the Council to write to doctors at the addresses provided to ask whether they want their names to remain on the register.

If doctors do not respond within six months, their names will be removed from the medical register.

Lost doctors

In this issue of *Medical Council News* we list several "lost doctors" whom we cannot trace because they have failed to let us know their new addresses. (See pg 13)

If you change your address, you must let us know your new address within one month. You can change your address online at www.mcnz.org.nz Registration>>Currently registered doctors>>Change your personal details

New requirements for certificates of good standing

The Council has changed its requirements for certificates of good standing (CGS).

From 1 August 2008, all doctors applying for registration in New Zealand will need to supply certificates of good standing from each jurisdiction in which they have been registered in the last five years (the present requirement applies to the last three years). As well, doctors who disclose any concerns about competence, conduct or health, will need to supply a CGS from the jurisdiction in which the doctor was registered at the time, regardless of time elapsed.

Why have we changed the CGS requirement?

The Health and Disability Commissioner's (HDC) report in February 2008 about the Whanganui District Health Board and Dr Roman Hasil raised the question of whether the three-year period is sufficient. The Council, in its submissions to the HDC, undertook to review this requirement.

Other jurisdictions, notably the General Medical Council in the United Kingdom, the Medical Board of South Australia and the New South Wales Medical Board require a CGS for the previous five years of a doctor's practice.

Each of these jurisdictions also require the CGS to cover every country where the doctor is registered, irrespective of whether the doctor has practised in that country over the five-year period.

More information about the change

In the coming weeks the Council will be changing its forms and website to reflect the changed requirement. We will also be advising DHBs, recruitment agents and overseas registration authorities about the change.

If you would like more information on these changes, please contact jrutherford@mcnz.org.nz.

New vocational scope, rural hospital medicine

The Medical Council has recognised a new vocational scope, rural hospital medicine.

Council chair, Professor John Campbell says, the new scope will help with workforce management in rural areas by creating a career pathway for those doctors working in the rural sector.

Another major benefit for patient safety is that these doctors will now undergo an accredited training programme.

Rural hospital medicine is determined by its social context, the rural environment, the demands of which include professional and geographic isolation, limited resources and special cultural and sociological factors.

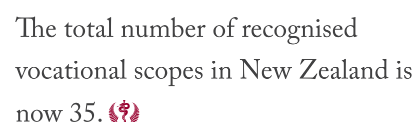
Often practised at a distance from specialist medical and surgical services, doctors in rural hospital medicine will need a broad generalist set of skills, knowledge and attitudes to deliver quality patient outcomes in rural hospitals. Unlike rural general practice, rural hospital medicine is focused on secondary care.

To be recognised as a vocational scope, the applicant body must meet the following criteria:

- clearly identify with empirical evidence how the new scope fulfils a recognised health need and contributes to improved medical care; and
- provide evidence to support being a new or separate scope. This should be based on major developments in medical science or health care delivery, identifying societies and journals devoted to the scope; and
- have a defined body of knowledge and practice specifically identifiable with the new vocational scope.

The applicant body must also be accredited to operate training and continuing professional development programmes.

The total number of recognised vocational scopes in New Zealand is now 35.



Interested in contributing to Council policy and research projects?

Are you registered within a vocational scope of practice? Do you have knowledge of, and experience in, maintenance of professional standards and assessment and research methods? Are you interested in medical education?

We need a medical adviser

The Council needs a medical adviser to work in its Wellington office. The medical adviser reports to the chief executive officer and works closely with each of our service areas. Key aspects of the medical adviser role include:

- providing input into policy and research projects for the Council
- advising on competence reviews and programmes
- assisting with health, education, and registration processes.

Role of the Council

The Council is the regulatory body set up to protect the health and safety of the public by ensuring that doctors are competent to practise medicine. The Council registers doctors to practise medicine in New Zealand and regulates doctors' education, performance standards, conduct and health.

Working arrangements

The position will be for three days (24 hours or 0.6 FTE) each week and the successful applicant will also be required to continue active clinical practice. Flexible working arrangements can be negotiated to allow the successful applicant to meet other professional commitments.

More information

For more information or a job description, please phone Valencia van Dyk on 0800 286-801 extn 992 or go to the vacancies page on our website, **www.mcnz.org.nz**.

Send your application (including a covering letter and CV) to:

Human Resources Manager
Medical Council of New Zealand
P O Box 11 649
Wellington

You can also email your application to **vvandyk@mcnz.org.nz**.

Is your email address the right one?

During the next couple of years the Council will be moving to providing more of its services online, including communicating with doctors via email.

Doctors need to be aware that the email addresses they provide to the Council will increasingly be used to correspond with or contact them.

There have been occasions where we have sent an email containing confidential material to a doctor and it has been opened legitimately by someone other than the person it was addressed to, such as the practice manager. This has caused embarrassment for everyone involved.

When providing an email address to the Council for our records, please keep in mind who knows or has access to your email password and email correspondence to avoid this situation happening.

If you would like to change the email address you have provided to us you can update it:

- during your next annual practising certificate renewal
- by emailing **mcnz@mcnz.org.nz**
- online at **www.mcnz.org.nz** **Registration**>>Currently registered doctors>>Change your personal details