Consultation on strengthening recertification for vocationally registered doctors

24 January 2017

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.

Purpose of this paper

This consultation paper reviews the current recertification requirements for vocationally registered doctors and proposes new requirements and standards for medical college accreditation that align with the Medical Council of New Zealand's (Council) *Vision and Principles for Recertification.*

Background

Doctors working in New Zealand are respected for the high standard of care they provide and are one of the most trusted groups in New Zealand.[i] The profession and Council need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted. One way of achieving this is by Council setting and recognising recertification programmes.[1]

Council needs to ensure that recertification programmes for doctors are robust, help assure the public that the doctor is competent and fit to practise, and improve the standards of practice. Council achieves this by setting standards and accrediting providers of recertification programmes. The medical colleges, as providers of the programmes, are charged with ensuring each doctor completes their recertification programme and they determine details of audit of medical practice and peer review.

Council has traditionally regarded continuing professional development (CPD) as the key mechanism for recertification. The report to Council by Associate Professor Robert Large in 1997[ii] highlighted the leadership that medical colleges had already begun in this area. However, Council recognises that more focus is required to ensure the effectiveness of CPD activities on performance.

Traditional methods of completing CPD have been shown to be limited in effectiveness.[iii, iv] CPD is more effective when it is linked to baseline performance[v] and when it addresses an individual doctors learning needs[vi]. However doctors do not always recognise their own learning deficits and needs[vii]. Knowledge and performance may also deteriorate as doctors age.[viii] Council's recertification programmes and activities should provide quality assurance and support continuing improvement in performance.

Current recertification requirements

All recertification programmes currently require a minimum of 50 hours of activity per year which must include at least:

- A minimum of 10 hours of peer review.
- A minimum of 20 hours of continuing medical education (CME).
- Participation in an annual audit of medical practice.

[1] Section 41 of the Health Practitioners Competence Assurance Act 2003

Doctors registered in a vocational scope of practice
Doctors registered in a vocational scope of practice meet recertification requirements by participating in accredited recertification programmes provided by their respective medical colleges. Medical colleges are responsible for ensuring that doctors participating in their recertification programmes meet the set requirements.

Doctors registered in a general scope of practice
Doctors registered in a general scope of practice, and who are not in a vocational training programme, meet recertification requirements by participating in the *Inpractice* programme administered by bpac[nz].

In addition to the peer review, CME and audit activities, each generally registered doctor must also:

- Develop a professional development plan (PDP).
- Complete the Essentials quiz (a knowledge test based on Council's statements).
- Undergo a regular practice review (RPR), every three years.
- Complete multisource feedback (MSF), every three years.
- Have a collegial relationship with a vocationally registered doctor.

Vision and principles for recertification

In 2015, Council consulted stakeholders on its *'Vision and Principles for Recertification'*. Amendments were made following the consultation feedback and the final *Vision and Principles for Recertification* were approved and published on the Council website in early 2016.

There was general agreement that recertification activities should reflect each doctor's individual learning needs and support continual improvement in performance. Feedback also indicated support for each doctor having an individualised PDP targeted to their identified development needs.

Vision and Principles for Recertification

Vision
Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support continuing improvement in performance.

Principles
Quality recertification activities are:

- Evidence-based.
- Formative in nature.
- Informed by relevant data.
- Based in the doctor's actual work and workplace setting.
- Profession-led.
- Informed by public input and referenced to the *Code of Consumers' Rights*.
- Supported by employers.

16 February 2016

Feedback from the Council's annual medical college meetings and from submissions indicated a need for Council to provide further guidance about how medical colleges should develop their recertification programmes to align with the vision and principles.

Proposal

Council is proposing to set new standards for recertification programmes that will replace current recertification requirements.

Medical colleges will need to develop recertification programmes that meet these standards and are appropriate for their vocational scope(s) of practice. The leadership of the profession in this is critical. Recertification activities need to be based on doctors receiving feedback within an open and supportive environment. Good feedback within this environment becomes a driver for change.

Profession-led recertification is a privilege that also has responsibilities which include setting standards and ensuring all doctors strive to meet those standards. Recertification should focus on improving the practice of doctors relevant to their specific clinical responsibilities, practice, and the health service settings in which they work.

Recertification activities are formative. Doctors participate in activities in which they receive feedback to guide their individual education and CPD. The feedback is not aimed at assessing whether the doctor is performing at the required standard of competence but rather at supporting continuing improvement in practise.

In order to achieve recertification, vocationally registered doctors will be required to:

1. **Participate in an accredited recertification programme based on a set of requirements.**
2. **Develop an individualised Professional Development Plan (PDP).**
3. **Complete CPD activities to address their PDP.**

To support the recertification model, medical colleges will need to:

4. **Ensure recertification programmes for vocationally registered doctors meet new accreditation standards.**
5. **Provide Regular Practice Review as an option for their doctors.**
6. **Assist doctors to use performance and outcome data to develop their PDP.**
7. **Provide additional support to doctors depending on their individual professional development needs.**
8. **Provide support to doctors to implement their PDP and assess satisfactory progress toward their PDP goals.**
9. **Collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement.**

Note:

10. **Council 'additional criteria' for all recertification programmes will be incorporated into the accreditation standards.**

The details of these proposed requirements are set on pages 5, 6, and 7, indicating how these affect both the individual doctor and the medical colleges.

Proposed requirements for individual vocationally registered doctors

1. Each doctor will need to participate in an accredited recertification programme based on the following:

a. Good quality performance and outcome data to identify individual professional development needs. Qualitative performance and outcome data allows clinicians to reflect on their own performance as well as plan for their on-going learning. At a minimum the following performance and outcomes data should be used:

i. Outcomes from audit of medical practice (participation required each year).

ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires).

iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is a structured conversation with a designated senior colleague. This could extend to Regular Practice Review (RPR) every three years, taking into account the individual doctor's needs.

b. Identification of individual professional development needs, taking into account the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence practise.

c. Career management planning for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement[ix]. Examples of career changes that may be considered include:

- Alterations to case mix.
- Locations of work.
- Hours or shifts.
- A move away from working as a solo practitioner to the more supportive environment of group practice.

A structured conversation provides a good opportunity to discuss career management.

Employers appreciate open discussion on these matters in an attempt to meet the needs of individual employees, teams, and service delivery.

2. An individualised PDP targeted to identified professional development needs.
Doctors will be expected to review their own PDP each year using performance and outcome data (listed above 1.a. i., ii., iii), noting that as they progress their career their learning needs change.

3. Completion of CPD activities to address the PDP.

Proposed requirements for medical colleges

4. Council accredited recertification programmes for vocationally registered doctors will need to meet new accreditation standards based on the following requirements:

a. **Defining knowledge requirements**
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[2], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*. Cultural competence and the *Code of Health and Disability Services Consumer's Rights* are fundamental to the practice of medicine and therefore emphasis needs to be placed on these.

b. **Identifying professional development needs**
Each medical college is responsible for assisting their doctors to use performance and outcome data to identify individual professional development needs. Qualitative performance and outcome data allows clinicians to reflect on their own performance as well as plan for their on-going learning.

At a minimum, the following performance and outcome data should be used:

i. Outcomes from audit of medical practice (participation required each year).
ii. Results from multisource feedback (colleague and patient feedback collected using standard questionnaires).
iii. Feedback from a review undertaken by peers external to the doctor's usual practice setting. The form of this external peer review could be different in different years. The minimum each year is for the doctor to have a structured conversation with a designated senior colleague. This could extend to RPR every three years, taking into account the individual doctor's needs.

5. Regular Practice Review (RPR)
Each medical college will be required to provide RPR as an option for their doctors. RPR will be made available to doctors to undertake on a voluntary basis or where closer review and support is indicated. The RPR model may include different components depending on the area of medicine and each medical college would need to develop an RPR model appropriate for their vocational scope(s). See Council's *Policy on regular practice review*.

6. Developing an individualised PDP
Each medical college is responsible for assisting their doctors to use the performance and outcome data (listed above 4b. i., ii., iii.) to develop a PDP that addresses their individual identified professional development needs.

7. Additional support
a. There may be times when doctors require additional support. When identifying an individual doctor's professional development needs consideration must be given to the knowledge of the doctor, the stage of progression in their career,

[2] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

their work requirements and other factors that can influence the performance of a doctor. For example, doctors who have recently gained vocational registration, doctors training in new procedures or a new scope of practice, or the ageing doctor.

b. Career management planning is recommended for all doctors. It is important for the older doctor to plan their withdrawal from clinical work and their transition into retirement.[ix] Examples of career changes that may be considered include:
   - Alterations to case mix.
   - Locations of work.
   - Hours or shifts.
   - A move away from working as a solo practitioner to the more supportive environment of group practice.

   A structured conversation provides a good opportunity to discuss career management.

   Employers appreciate open discussion on these matters in an attempt to meet the needs of individual employees, teams, and service delivery.

8. Completion of CPD activities

Each medical college is responsible for supporting their doctors to implement their PDP. This will include ensuring each doctor makes satisfactory progress towards their PDP goals each year.

9. Continuous quality improvement

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.

10. Existing criteria for accreditation of medical colleges

In addition to the proposed model for recertification, the following existing Council 'additional criteria' for all recertification programmes will be incorporated into the accreditation standards. Medical colleges will need to:

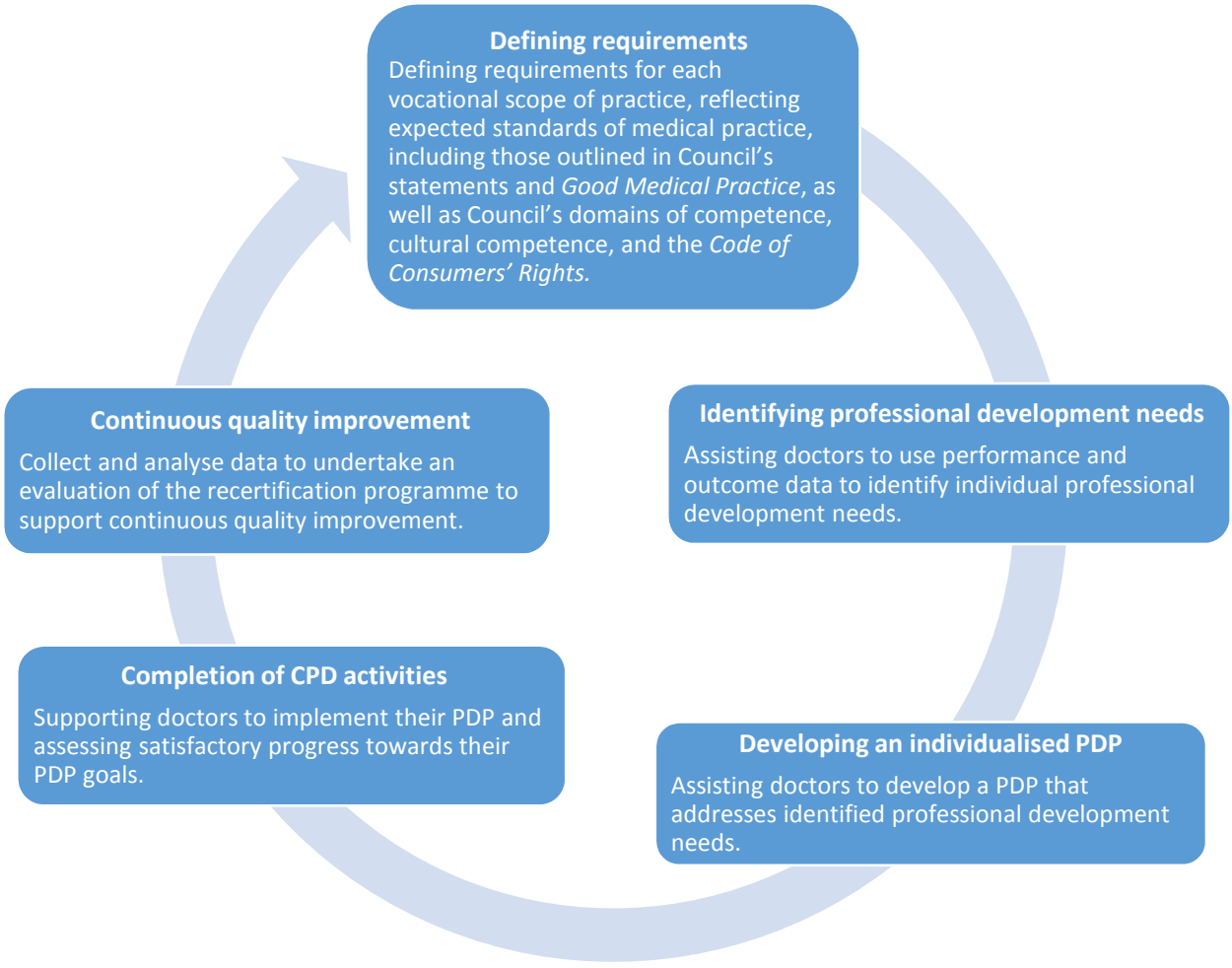
a. Inform Council of the categories of practitioners and numbers of practitioners undertaking their recertification programme.
b. Inform Council of any practitioners not enrolled in recertification programmes.
c. Confirm whether their recertification programme is available for practitioners registered within a vocational scope of practice who are not fellows or members.
d. Have a process for auditing and reporting to Council whether individual practitioners are participating in the recertification programme and whether they are meeting requirements. This includes a system for dealing with those who are not complying.
e. Inform Council of the numbers of and outcomes for practitioners who undertake RPR.
f. Have a system for informing Council if the medical college becomes aware of performance/competence concerns on the part of the practitioner.
g. If the medical college seeking accreditation is not the direct provider of the recertification programme in New Zealand, then the medical college will need to provide evidence that the provider to which they delegate meets Council's requirements.

Transition period for new requirements

Council proposes that the proposed model for recertification is implemented over a transitional three year period. This period will commence from the time Council communicates its final decisions following consultation.

Each medical college would be expected to meet the new standards for accreditation of recertification programmes after this time and will be assessed against the standards when they are next accredited following the transition period.

Proposed model for recertification: medical college responsibilities



Feedback

While Council has provided some guiding questions for submissions, you are invited to provide any feedback you consider is relevant for Council to consider.

A form has been provided for you to complete – see Appendix 1.

You may submit your completed submission via email to:
recertificationconsultation@mcnz.org.nz

Or by post to:
Karen Davis
Senior Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143
New Zealand

Submissions may be made until **5pm, Friday 10 March 2017.**

Next steps

Following the close of submissions, Council will consider all feedback. The feedback will inform decisions about the final model, with changes incorporated as appropriate.

Appendix 1

Guiding questions for submissions

Proposal:
Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Question 1:
Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

Proposal:
Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Question 2:
Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

Proposal:
Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, *Good Medical Practice*, Council's domains of competence[3], cultural competence, and the *Code of Health and Disability Services Consumer's Rights*.

Question 3:
What is your view of medical colleges defining knowledge requirements?

Proposal:
Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Question 4:
Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

[3] Council's domains of competence include: medical care; communication; collaboration and management; scholarship; professionalism

Proposal:
Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Question 5:
Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

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?

Proposal:
Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement

Question 7:
Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

General Questions:

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?

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?

Question 10:
Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

[i] Institute for Governance and Policy Studies, Colmar Brunton. 'Who do we trust?'. Victoria University March 2016

[ii] Large RG, 'Maintaining Doctors' Competence. A report for the Medical Council of New Zealand June 1997

[iii] Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P and Taylor-Vaisey A. 'Impact of Formal Continuing Medical Education: D Conferences, Workshops, Rounds and Other Traditional Continuing Education Activities Change Physician Behaviour or Health Care Outcomes?' *JAMA 1999*; *282(9);* 867-74

[iv] Brown CA, Belfield CR and Field SJ. 'Cost Effectiveness of Continuing Professional Development in Health Care: A Critical Review of the Evidence'. *British Medical Journal 2002;324 (7338):*652-5

[v] Davis, D. A, Thomson M.A, Oxman A.D, and Haynes R.B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA: The Journal of the American Medical Association, 274(9), 700-705

[vi] Schostak J, Davis M, Hanson J, Schostak J, Brown T, Driscoll P, et al. (2010) Effectiveness of continuing professional development pro¬ject: a summary of findings. Med Teach;32(7):586–92.

[vii] Davis DA, Mazmanian PE, Fordis M, van Harrison R, Thorpe KE, and Perrier L. 'Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence; A Systematic Review'. *JAMA 2006; 296(9);* 1094-1102

[viii] Choudhry NK, Fletcher RH and Soumerai SB, 'Systematic Review: The Relationship Between Clinical Experience and Quality of Health Care. *Ann Intern Med 2005; 142(4);* 260-273

[ix] Lillis S, Milligan E. The Ageing Doctor. Australasian Journal on Ageing. In Press