



Reaccreditation of Specialist Medical
Education and Training and Continuing
Professional Development Programmes:

Standards and Procedures for
New Zealand Colleges

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Reaccreditation standards for training providers and their specialist medical education and training programmes and professional development programmes

The Medical Council of New Zealand (the Council) is committed to ensuring that specialist training and professional development programmes are of a high standard to meet the needs of the public. As such, it has a joint memorandum of understanding on a common accreditation process with the Australian Medical Council for those training organizations providing such programmes in both Australia and New Zealand. The Council requires training organizations in New Zealand to satisfy essentially the same standards in the interests of maintaining consistency between both countries and ensuring the delivery of high quality health care to the people of New Zealand. Both sets of standards include New Zealand-specific requirements.

Goals and Objectives of Specialist Medical Education

The broad goals of specialist education and training are:

1. To produce medical specialists who:
 - have demonstrated the requisite knowledge, skills and professional attributes necessary for independent practice through a broad range of clinical experience and training in the relevant specialty
 - can practice unsupervised in the relevant medical specialty, providing comprehensive, safe and high quality medical care, including the general roles and multifaceted competencies inherent in all medical practice and within the ethical standards of the profession and the community they serve.
2. To produce medical specialists with a high level of understanding of the scientific and evidence base of the discipline.
3. To produce medical specialists able to provide leadership in the complex health care environments in which they practice, to work collaboratively with patients and their families, and the range of health professionals and administrators, and to accept responsibility for the education of junior colleagues.
4. To produce medical specialists with knowledge and understanding of the issues associated with the delivery of safe, high quality and cost effective health care within the New Zealand health system.
5. To prepare specialists able to assess and maintain their competence and performance through continuing professional education, the maintenance of skills and the development of new skills.

1 THE CONTEXT OF EDUCATION AND TRAINING

1.1 RESPONSIBLE RESOURCE UTILISATION

1.1.1 The specialisation represented by the separate scope of practice is a wise use of resources.

Notes

The training organisation should identify any similar existing or overlapping scopes and how the vocational scope enhances the quality of healthcare in New Zealand. It should also justify how specialisation is not, and will not, adversely affect the quality of healthcare in New Zealand, through: unnecessary fragmentation of medical knowledge and skills or of medical care delivery; or unnecessary deskilling of other medical practitioners; or exacerbating inequitable access to health care as defined by socioeconomic status, geography or culture.

Small training organisations should describe how they will efficiently manage their administrative affairs, and are encouraged to consider collaboration with a larger training organisation to this end.

1.2 SUSTAINABLE BASE

1.2.1 The training organisation has a demonstrable and sustainable base in the medical profession, indicated by a sufficient number of practitioners.

Notes

The training organisation must demonstrate it has a sufficient number of practitioners, with capacity to meet existing clinical need, who possess the knowledge and skills to practise in the specialty, and who practise predominantly in the specialty. It must also demonstrate that activities such as vocational training, assessment and recertification can be sustained and that there are sufficient doctors entering training to sustain the specialty.

1.3 GOVERNANCE

1.3.1 The training organisation's governance structures and its education and training, assessment and continuing professional development functions are defined.

1.3.2 The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.

1.3.3 The training organisation's internal structures give priority to its educational role relative to other activities.

Notes

Governance structures include the training organisation's relationships with regions and any specific special societies, chapters and faculties.

Relevant groups would include programme directors, supervisors, trainees, scientific societies, health service managers and professional associations. Training organisations are encouraged to include appropriate health consumer representation on decision-making bodies.

The Council recognises that the governance structures and the range of functions vary from training organisation to training organisation. The Council does not consider any particular structure is preferable, and supports diversity where the structure can be demonstrated to function effectively over time.

1.4 PROGRAMME MANAGEMENT

1.4.1 The training organisation has specifically nominated its board or individual office bearers or has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:

- planning, implementing and reviewing the training programme(s) and setting relevant policy and procedures
- setting and implementing policy and procedures relating to the assessment of overseas-trained specialists
- setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.

1.4.2 The training organisation's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

Notes

The group or individuals responsible for designing the curriculum and overseeing its delivery should include those with knowledge and expertise in medical education. Their perspective should encompass local and national needs in health care and service delivery, and national health priorities.

1.5 EDUCATIONAL EXPERTISE AND EXCHANGE

1.5.1 The training organisation uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.

1.5.2 The training organisation collaborates with other educational institutions and compares its curriculum, training programme and assessment with that of other relevant programmes.

Notes

Educational expertise would include clinicians with experience in medical education and educationalists.

1.6 INTERACTION WITH THE HEALTH SECTOR

1.6.1 The training organisation seeks to maintain constructive working relationships with relevant stakeholders⁴ to promote the education, training and ongoing professional development of medical specialists.

⁴ Stakeholders may include Council, District Health Boards, Health Workforce New Zealand, the National Health Board, the Ministry of Health, the Minister of Health, the Health and Disability Commissioner, the Accident Compensation Corporation and other non government and community agencies and consumer groups in the health sector.

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- 1.6.2 The training organisation works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

Notes

Specialist medical education and training programmes depend on strong and supportive publicly funded and private health care institutions and services. Many benefits accrue to health care institutions and health services through involvement in medical education and training. Teaching and training, appraising and assessing doctors and students are important functions for the care of patients now and the development of a highly skilled workforce to care for patients in the future.

The Council considers it essential that the institutions and health services involved in medical education and training are appropriately resourced to provide educational experience in these settings. It recognises this is not a matter over which individual training organisations have control.

Trainees have dual interdependent roles which can create tension. They are both workers in the health care system and students completing postgraduate medical programmes. Demands on the health system can lead employers to emphasise the trainee's service delivery role at the expense of training. At the same time, training organisations are responding to pressures for improved training by seeking intensified training and a greater focus on workplace-based assessment. Accommodating these interdependent roles so that trainees can meet educational and service delivery requirements is a joint responsibility.

The duties, working hours and supervision of trainees should be consistent with the delivery of high quality, safe patient care. Ensuring trainees can meet their educational goals and service delivery requirements within safe hours of work is the responsibility of all parties.

There must be effective consultation between the training organisation and the health care institutions that provide clinical training on matters of mutual interest, such as teaching, research, patient safety and clinical service. This should include a formal mechanism for high level consultation and agreements concerning the expectations of the respective parties, and extend to regular communication with the relevant stakeholders.

1.7 CONTINUOUS RENEWAL

- 1.7.1 The training organisation reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.

Notes

The Council expects each training organisation to engage in a process of educational strategic planning, with appropriate input, so that its curriculum, training and continuing professional development programmes reflect changing models of care, developments in health care delivery, medical education, medical and scientific progress and changing community needs.

It is appropriate that review of the overall programme leading to major restructuring occurs from time to time, but there need also to be mechanisms to evaluate, review and make more gradual changes to the curriculum and its components.

When a training organisation plans new training requirements or a new training programme, trainees in transition should be included in the strategic planning. In managing changes to education, training

and assessment requirements, training organisations are expected to consider the effect of plans for change on those trainees. The Council advises that in making programme changes, organisations should be guided by the principle of ‘no disadvantage to trainees’ specified under standard 6.1.3. In general, the Council supports generous application of transitional exemption clauses and retrospective accreditation for training completed under previous regulations.

2 THE OUTCOMES OF THE TRAINING PROGRAMME

2.1 PURPOSE OF THE TRAINING ORGANISATION

2.1.1 The purpose of the training organisation includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.

2.1.2 In defining its purpose, the training organisation has consulted fellows and trainees, and relevant stakeholder groups.

Notes

Relevant stakeholder groups include government agencies, the medical profession, health service providers, bodies involved with medical training, health consumer organisations and the community.

Training organisations are encouraged to engage consumers to develop specialist training and education programmes that meet community expectations.

Similarly, training organisations should engage the diverse range of employers of medical specialist trainees in developing training and education programmes that have due regard to workplace requirements.

2.2 GRADUATE OUTCOMES

2.2.1 The training organisation has defined graduate outcomes for each training programme including any sub-specialty programmes. These outcomes are based on the nature of the discipline and the practitioners’ role in the delivery of health care. The outcomes are related to community need.

2.2.2 The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.

2.2.3 The training organisation makes information on graduate outcomes publicly available.

2.2.4 Successful completion of the programme of study must be certified by a diploma or other formal award.

Notes

The Council's goals of specialist medical training, set out above, indicate that training should prepare specialists able to fill the general roles and multifaceted competencies that are inherent in medical practice, as well as the role of clinical or medical expert.

There are a number of documents that describe these general attributes². These documents are designed as guides to the professional conduct and the breadth of knowledge and skills, including clinical, interpersonal and technical skills, and abilities such as problem solving and clinical judgement expected of individual doctors. Training organisations are expected to define the broad roles of practitioners in their discipline and relevant graduate outcomes. The training programme should prepare specialists to undertake these broad roles and prepared them to maintain and enhance their performance.

3 THE EDUCATION AND TRAINING PROGRAMME - CURRICULUM CONTENT

3.1 CURRICULUM FRAMEWORK

3.1.1 For each of its education and training programmes, the training organisation has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publicly available.

3.2 CURRICULUM STRUCTURE, COMPOSITION AND DURATION

3.2.1 For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.

3.2.2 Successful completion of the training programme is certified by a diploma or other formal award.

Notes

Specialist education and training builds on the knowledge, skills and professional qualities developed in medical school, during internship and other prevocational training.

Recognised medical specialties in Australasia share a number of characteristics:

- The scope of training, assessment and practice in each specialty is wide.

² Medical Council of New Zealand 2011 *Coles Medical Practice in New Zealand*, Chapter 1 at <http://www.mcnz.org.nz/assets/News-and-Publications/Coles/Chapter-1.pdf>.

The CanMEDS 2005 Physician Competency Framework at

http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/resources/publications/framework_full_e.pdf

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- The group of conditions managed by the specialty has common features and is of public health importance.
 - The public health significance and common grouping of health problems managed by the specialty is usually reflected by establishment of the specialty in other countries with similar health systems.
 - The specialty is based on sound, evidence-based clinical and scientific principles.
 - Because of the scope of practice and complexity of the specialty, there is an extensive theoretical and practical training programme.

For most specialties, the period of formal training ranges from three to six years when, following an appropriate summative assessment, a diploma or Fellowship or other qualification is granted. Many trainees continue formal training beyond the conferring of fellowship or its equivalent and this may be recognised by awards such as a post-fellowship diploma. Some trainees undertake research towards a higher academic degree during or after completion of their specialist education and training.

Many specialist education and training programmes provide for a period of basic training. During this stage, there is particular emphasis on gaining knowledge of the basic sciences underlying the discipline, and on acquiring and enhancing the clinical and diagnostic skills that are the prerequisite for training to practise the specialty.

This stage is followed by advanced training when knowledge, clinical and diagnostic skills, and professional qualities are further developed until they are at the level of a specialist undertaking independent practice in the discipline.

In some programmes, there is integration of basic and advanced training.

The term 'sub-specialisation' is frequently used to describe narrow specialisation within a broad discipline. Overseas many specialist training programmes allow trainees to focus their training in a specialist/sub-specialist area. The Council believes that such training should take account of the broader educational objectives for the discipline/specialty as a whole. The Council believes that the New Zealand and Australian communities and health systems are better served by avoiding unnecessary fragmentation of medical knowledge, skills and medical care. Where a training organisation encompasses sub-specialty or similar categories, it will be expected to provide a rationale and outline of such programmes in its accreditation submission.

Where training programs are the joint responsibility of two or more training organisations the Council will determine, with the sponsoring organisations, how such programs will be assessed in the accreditation of each organisation's programs.

3.3 RESEARCH IN THE TRAINING PROGRAMME

3.3.1 The training programme includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.

3.3.2 The training programme allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.

Notes

Exposure to an atmosphere of enquiry, intellectual curiosity and evidence-based practice promotes the enduring ability to solve problems, analyse data and update knowledge and improve practice. Not all trainees will have the inclination, opportunity or aptitude for an extended period of research activity, but it is essential that all trainees acquire knowledge of research methodology, and are competent in critical appraisal of research literature and in applying evidence when making clinical decisions. This may require the completion of specifically designed learning programmes approved by the relevant training organisation.

Trainees should have the opportunity for research experience to enable those interested to pursue medical research in their future careers.

The academic development and leadership of individual disciplines depends on some trainees following an academic pathway. Academic advancement in New Zealand requires demonstration of merit in research as well as clinical activity and teaching.

The training structure can facilitate an early start to research, through intercalated research degrees, with appropriate credit towards completion of the training programme. Trainee presentation of research projects at discipline scientific meetings is highly desirable.

3.4 FLEXIBLE TRAINING

3.4.1 The programme structure and training requirements recognise part-time, interrupted and other flexible forms of training including entitlement to parental leave.

3.4.2 The programme is structured to provide opportunities for trainees to pursue studies of choice, consistent with training programme outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programmes both here and overseas, and give trainees appropriate credit towards the requirements of the training programme.

Notes

Policies about flexible training options should be readily available to supervisors and trainees. Training organisations should provide guidance and support to supervisors, trainers and trainees on the implementation and review of flexible training arrangements.

Training organisations are encouraged to monitor and report on the take up of flexible training options, and to measure their success by incorporating appropriate questions in surveys and by analysing the pattern of applications by trainees. They are also encouraged to work with the health services to create appropriate opportunities for flexible training.

Training organisations must be able to demonstrate that they have in place clear criteria and processes for assessing trainees' prior learning.

3.5 THE CONTINUUM OF LEARNING

3.5.1 The training organisation contributes to articulation between the specialist training programme and prevocational and undergraduate stages of the medical training continuum.

Notes

Vocational training is one step in the education of doctors. Other phases include undergraduate medical education, prevocational training, research training, and continuing professional education. The Council considers that collaboration between the various bodies concerned with medical education is essential to achieve appropriate quality assurance across the continuum of medical education.

The Council regards the prevocational years as pivotal; doctors develop generalised medical knowledge, attitudes and skills to equip them to proceed to specialist training and practice. This period gives particular emphasis to practical experience, as the intern assumes responsibility for patient care. Therapeutic and procedural skills are developed under appropriate supervision. Communication and counselling are practiced and consolidated.

The Council considers that specialist training cannot be considered in isolation from the earlier stages of medical education and training, particularly the education, experience and training obtained during the intern year and other prevocational training. A complementary relationship is essential. Thus the Council supports activities that aim to develop the linkage between prevocational training and vocational training.

Continuing professional development designates the education and training of doctors extending throughout each doctor's professional working life. The learning activities start in medical school and continue as long as the doctor is engaged in professional activities. The goals of the training programme should make it clear that learning is not complete at the time of the award of the diploma but should be enhanced throughout a professional career.

4 THE TRAINING PROGRAMME - TEACHING AND LEARNING

4.1 THE TRAINING PROGRAMME

- 4.1.1 The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.
- 4.1.2 The training programme includes appropriately integrated practical and theoretical instruction.
- 4.1.3 The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

Notes

It is expected that, predominantly, education and training will occur in and through the work environment with the application of adult learning skills. While much of the learning will be self-directed learning related to educational objectives, the trainee's supervisors and trainers will play key roles in the trainee's education.

In the traditional apprenticeship approach, trainees learn best when trainers demonstrate appropriate skills, abilities and attitudes in the clinical environment. This model also allows trainees

continually to apply their knowledge within the clinical environment in which they will ultimately function as fully trained specialists.

Other learning opportunities supplement apprenticeship training, such as:

- structured educational programmes relevant to trainees' needs and to clinical needs, and based on adult learning principles. Educational programmes should include: tutorials on the scientific basis of the discipline; relevant clinical topics, procedures and skills; staff rounds; postgraduate meetings; other quality assurance programmes, including meetings to identify and respond to adverse events; and where relevant clinicopathological sessions; radiology conferences; pathology conferences; mortality and morbidity audits;
- sessions addressing topics not easily taught within the service environment, such as communication skills;
- opportunities to practise specific procedural skills in a safe (e.g. simulated) environment prior to gaining further experience in practice;
- opportunities to rehearse dealing with certain difficult events;
- formal off-site degree/diploma programmes as appropriate to the specialty.

4.2 CULTURAL COMPETENCE

4.2.1 The training programme ensures that trainees, fellows and affiliates have access to significant training experiences in cultural competence and that evaluation of cultural competence is a specific component of the training programme.

Notes

Council has defined cultural competence as follows: "Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. The full Statement on Cultural Competence can be found at <http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf>.

The Council has set standards for cultural competence and has an expectation that medical specialists will demonstrate cultural competence in their practise of medicine. The Treaty of Waitangi seeks to protect the rights of Maori as tangata whenua and this includes the right to good health yet Maori still, as a group, have poorer health outcomes than pakeha. Health disparities also exist in all parts of the Pacific communities even after socioeconomic status and other factors are controlled for.

The Council defines culture broadly – extending beyond ethnicity and recognising that patients identify with multiple cultural groupings. These include (but are not limited to) gender, spiritual and other belief systems, sexual orientation, disability, lifestyle, age and socioeconomic status.

Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this.

Training organisations should be familiar with the Council's definition of cultural competence³. Colleges are expected to have programmes to acculturate overseas trained specialists to New Zealand clinical practice. Training and recertification (CPD) programmes must include components that demonstrate an understanding of and respect for cultural competence.

³ www.mcnz.org.nz/portals/0/guidance/cultural%20competence.pdf

5 THE CURRICULUM - ASSESSMENT OF LEARNING

5.1 ASSESSMENT APPROACH

- 5.1.1 The assessment programme, that includes both summative and formative assessments, reflects comprehensively the educational objectives of the training programme.
- 5.1.2 The training organisation uses a range of assessment formats that are appropriately aligned to the components of the training programme.
- 5.1.3 The training organisation has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability.

Notes

Assessment is a powerful tool to drive learning, and methods of assessment should match and reinforce the goals and objectives of the education and training programme.

Assessment includes both summative assessment, for judgements about trainee progression, and formative assessment, for feedback and guidance. The training organisation's documents defining the assessment methods should address and outline the balance between formative and summative elements, the number and purpose of examinations (including a balance between written and practical examinations) and other assessment requirements, and make explicit the criteria and methods by which any judgments based on the various assessments employed are made.

Contemporary approaches to assessment in medical education emphasise a programmatic approach where multiple measures of trainees' knowledge, skill and abilities over time are aggregated to inform judgements about progress. Assessment programmes are constructed through blueprints or assessment matrices which match assessment items or instruments with outcomes. The strength of an assessment programme is judged at the overall programme level rather than on the psychometric properties of individual instruments. In such an approach highly reliable methods associated with high stakes examinations such as multiple choice questions (MCQ), modified essay questions (MEQ) or objective structured clinical examinations (OSCE) are used alongside instruments to measure domains such as independent learning, communication with patients and their families, working as part of a health team, development of professional qualities and problem solving skills where reliability is less well established. The Council encourages the development of assessment programmes for their educational impact. A balance of valid, reliable and feasible methods should drive learning to the programme goals and outcomes.

In clinical specialties, clinical examinations, whether on real or simulated patients, should form a significant component of the assessment.

The Council encourages training organisations to utilise direct observation of trainee performance using performance-based assessment as well as other forms of clinical assessment.

Formative assessment has an integral role in the education of trainees as it enables the trainee to identify perceived deficiencies, and the supervisor to assist in timely and effective remediation. It also provides positive feedback to trainees regarding their attainment of knowledge and skills.

5.2 FEEDBACK AND PERFORMANCE

- 5.2.1 The training organisation has processes for early identification of trainees who are under-performing and for determining programmes of remedial work for them.
- 5.2.2 The training organisation facilitates regular feedback to trainees on performance to guide learning.
- 5.2.3 The training organisation provides feedback to supervisors of training on trainee performance, where appropriate.
- 5.2.4 The training organisation has processes for obtaining regular feedback from trainees regarding the training they receive.

Notes

Trainees encounter difficulties for many reasons including problems with systems, teaching, supervision, learning, exam performance and personal difficulties. Not all are within the power of the trainee to rectify. It is essential that training organisations have systems in place to monitor their trainees' progress, to identify trainees experiencing difficulty at an early stage and where possible to assist them to complete their training successfully using methods such as remedial work and re-assessment, supervision and counselling.

There may be times where the remediation and assistance offered is not successful and/or appropriate. For these circumstances, training organisations must have clearly defined policies relating to issues such as determining unsatisfactory periods of training and limits on duration of training time.

5.3 ASSESSMENT QUALITY

- 5.3.1 The training provider considers the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

Notes

When a training organisation changes the educational objectives of its training programme or a component of its programme, the assessment process and methods should reflect these changes; assessment should address and be developed in conjunction with the new objectives. Similarly, new or revised assessments should be introduced where evaluation of specific curriculum components and associated assessment reveals a need.

Specialist medical trainees undertake their training at a wide variety of clinical sites. It is essential that training organisations have systems to minimise variation in the quality of in-training assessment across clinical training sites in all settings.

5.4 RECOGNITION AND ASSESSMENT OF INTERNATIONAL MEDICAL GRADUATES (IMGs)⁴ HOLDING SPECIALIST QUALIFICATIONS

- 5.4.1 The training organisation has processes to:

⁴ For the purposes of this standard, the term "IMG" refers to non-Australasian doctors trained overseas who hold provisional vocational registration with the Medical Council of New Zealand.

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- assess the relative equivalence of IMG’s qualifications against the prescribed standards for their discipline;
 - advise the Council of any additional training or experience that would be required by the IMG to meet the criteria for vocational registration in New Zealand.

Notes

The Council has a statutory role in determining whether IMGs who have been trained and recognized as specialists overseas are fit and competent to practice within a vocational scope of practice and to decide whether to grant provisional vocational and vocational registration. This assessment activity is an important service for the community in ensuring that the standards of its medical services are maintained.

Training organisations advise the Council on the suitability for registration in New Zealand of IMGs recognized as specialists overseas. This process entails an assessment of the IMG by the training organisation and provision of comprehensive advice and recommendations on the IMG’s qualifications, training and experience and whether this is “equivalent to or as satisfactory as” specialists who have completed their training in New Zealand. This is the statutory definition and may not be the same standard as required for Fellowship of a training organisation.

The training organisation is required to have processes for:

- Assessing the relative equivalence of the IMG’s qualifications, training and experience against the prescribed New Zealand or Australasian Fellowship, Diploma or Certificate qualification for the relevant vocational scope.
- Notifying the Council in writing, if any significant concerns about competence become apparent during the assessment of QTE and thereafter.
- Clearly identifying differences between the IMG’s qualifications, training and experience, and the prescribed qualification (Fellowship) and whether there are any deficiencies or gaps in training, and whether subsequent experience has addressed these, and if not, what type of experience, supervised practice and assessment would address the deficiencies or gaps in training, to inform Council in making a decision.
- Advising the Council of any requirements the IMG would need to complete during the provisional vocational period of registration, toward obtaining registration in a vocational scope of practice, together with comprehensive reasons.
- Ensuring reports meet administrative law obligations, Privacy Act principles and principles by providing well reasoned advice directly supported by the paper documentation and information obtained at interview.
- Advising the Council on the content of vocational practice assessments.

6 THE CURRICULUM - MONITORING AND EVALUATION

6.1 ONGOING MONITORING

- 6.1.1 The training organisation regularly evaluates and reviews its training programmes. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.
- 6.1.2 Supervisors and trainers contribute to monitoring and to programme development. Their feedback is systematically sought, analysed and used as part of the monitoring process.
- 6.1.3 Trainees contribute to monitoring and to programme development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training programme to ensure that existing trainees are not unfairly disadvantaged by such changes.

Notes

Each training organisation should develop mechanisms for monitoring and evaluating its curriculum and for using the evaluation results to assess achievement of educational objectives. This requires the collection of data and the use of appropriate methods to monitor and evaluate education and training programmes.

The value of evaluation data is enhanced by a plan that articulates the purpose and procedures for conducting the evaluation, such as why the data are being collected, from whom and when, methods and frequency of data analysis, responsibility for receiving evaluation reports, and possible decisions or actions in response to particular findings. Indications of how and when poor results will be followed up are also part of an evaluation plan.

Some examples of changes that may unfairly disadvantage existing trainees include those that lengthen the period of training, introduce more assessment, or change the range or kinds of training placements required for fellowship.

6.2 OUTCOME EVALUATION

- 6.2.1 The training organisation collects and examines data on the outcomes of its training programme.
- 6.2.2 Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

Notes

Training organisations should consider methods of evaluation that ensure that recently graduated specialists are of a standard commensurate with community expectation. This may include specialist self assessment of their preparedness for practice and other multi-source feedback mechanisms.

7 IMPLEMENTING THE CURRICULUM – TRAINEES

7.1 ADMISSION POLICY AND SELECTION

- 7.1.1 A clear statement of principles underpins the selection process, including the principle of merit-based selection.
- 7.1.2 The processes for selection into the training programme:
- are based on the published criteria and the principles of the training organisation concerned
 - are evaluated with respect to validity, reliability and feasibility
 - are transparent, rigorous and fair
 - are capable of standing up to external scrutiny
 - include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.
- 7.1.3 The training organisation documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.
- 7.1.4 The training organisation publishes its requirements for mandatory experience, such as periods of rural training, and/or for rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.
- 7.1.5 The training organisation monitors the consistent application of selection policies across training sites and/or regions.

Notes

Trainees are both postgraduate students in specialist training programmes and employees of the health services. While the training organisation identifies doctors eligible to participate in its training programme, and employers determine who will be employed, the processes of selection for employment and for training can be interlinked. In some training programmes, potential trainees first obtain employment then apply for approval of their training programme. In others, the training organisation first selects those suitable for the training programme. Where another body such as the employing institution is primarily responsible for selection, the Council expects the training organisation will work actively to obtain the cooperation of such other stakeholders in implementing its selection principles. It is important that both training organisations and employers are involved in selection.

The training organisation, as the professional body for a particular medical discipline or disciplines, should take a leadership role in the development of the criteria for selection of entrants into training for the specialty. The training organisation and other key stakeholders should determine a framework of selection criteria and processes.

The Council does not endorse any one selection process; it recognises that there is no one agreed method of selecting the most appropriate trainees and supports diverse approaches that include both academic and vocational considerations. However it notes the principles in the report "Trainee Selection in Australian Medical Colleges" commissioned in 1998 by the Australian Medical Training Review Panel. The key principles are attached in Appendix 1 and commended as an example of best practice in relation to trainee selection.

7.2 TRAINEE PARTICIPATION IN TRAINING ORGANISATION GOVERNANCE

7.2.1 The training organisation has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

Notes

The purpose of trainee participation is to promote their understanding of and engagement in their training programme, to encourage them to be active contributors to the training organisation as fellows, and to enable decision-making to be informed by the users' perspective of the training programme. Trainee participation in training and assessment-related committees enhances the training organisation's understanding of how training and assessment policies work in practice. It also allows the committees that manage the training programme to identify and respond to problems at an early stage, and to recognise and expand successful strategies.

Committee and decision-making structures vary from training organisation to training organisation. The Council has no wish to suggest that any particular structure is most suited to engaging trainees in the governance of their training, but whatever the processes and structures applied, they must be formal and give appropriate weight to the views of trainees.

Two strategies commonly used to support the involvement of trainees are to establish positions for trainees on training organisation committees and to support a trainees' organisation or trainees' committee.

Within the constraints of the training organisation's structure, there should be a position for a trainee on the governing council and on every training-related committee. Possible constraints include legal ones such as the training organisation's constitution or articles of association, the large number of committees, conflicts of interest, and consideration of sensitive material. The extent of trainee involvement in committees unrelated to training could be determined by annual agreement between the training organisation and the trainees' committee or trainee representatives.

The trainees involved should be appointed through open processes supported and funded by the training organisation. Appointment by election by the body of trainees is the most open process possible.

A trainees' organisation or trainee committee can articulate a general overview of trainees' experience and common concerns, as well as promoting communication between trainees on matters of mutual interest, and facilitating the nomination of trainees to committees. There are advantages in establishing this committee or organisation within the training organisation, since this facilitates communication and sharing of information and data, and provides a structure for funding. Where the trainee body sits outside the training organisation structure, particular efforts are required to ensure shared understanding of obligations and expectations.

Trainee representatives, and trainees' organisations or committees are able to assist the training organisation by gathering and disseminating information. They require appropriate support for these roles. Successful models include providing administrative support or infrastructure, providing mechanisms for the trainees' organisation and the trainee members on training organisation committees to communicate with trainees, such as access to contact details or email lists, and designating a member of the staff to support the trainees in these activities.

Training organisations should supplement the organisational perspective of trainees obtained through the trainees' organisation or trainees' committee by seeking feedback on the experiences of individual trainees. A trainee representative structure should be complemented by regular meetings between training organisation officers and trainees to allow in-depth exploration of concerns and ideas at a local level. Because trainees' needs and concerns differ depending on their stage of training, location of training and personal circumstances, training organisations should ensure that the full breadth of the trainee cohort is able to contribute.

Local and regional educational activities also provide opportunities for trainees to share problems and experiences with peers, and for trainee representatives to canvas views on training-related issues. These activities can foster a sense of belonging to a professional peer group.

7.3 COMMUNICATION WITH TRAINEES

7.3.1 The training organisation has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.

7.3.2 The training organisation provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.

7.3.3 The training organisation provides timely and accurate information to trainees about their training status to facilitate their progress through training requirements.

Notes

Training organisations are expected to deal with their trainees in an open and transparent way. To ensure this occurs, they should have in place mechanisms to inform prospective and enrolled trainees of training policies and processes, including but not limited to:

- selection to the training programme;
- the design, requirements and costs of the training programme;
- proposed changes to the design, requirements and costs of the training programme;
- the available support systems and career guidance;
- recognition of prior learning and flexible training options.

As autonomous bodies, training organisations are able to respond quickly to pressures for change in the content and structure of vocational training by changing policies and structures, for example by changing the length of a training programme, adding new components to the programme or changing the format and timing of assessment. As these changes have significant consequences for trainees, trainees should participate formally in the evolution and change of the training programme. Training organisations should communicate in advance with trainees about proposed programme changes, be guided by the principle of 'no unfair disadvantage to trainees' specified under standard 6.1.3, and ensure special arrangements are proposed for those already enrolled when changes are implemented.

The strengths of training programmes, opportunities for specific experience and job opportunities in particular specialties vary from region to region. Information on career pathways should be available to assist trainees to choose their training programme and locations in an informed way. This should include information on workforce distribution issues and training opportunities. Training organisations are encouraged to collaborate with other stakeholders to ensure that career guidance

systems are in place. There should be similar collaboration on procedures to detect and support trainees who are experiencing personal and/or professional difficulties.

Trainees' progression through their training will be assisted by access to timely and correct information about the status of their training. Training organisations are encouraged to supplement written material with electronic communication of up to date information on training regulations, and on trainees' individual training status. Mechanisms to support communication on issues such as job sharing, part-time work or issues of concern should also be considered.

7.4 RESOLUTION OF TRAINING PROBLEMS AND DISPUTES

- 7.4.1 The training organisation has processes to address problems with training supervision and requirements confidentially.
- 7.4.2 The training organisation has clear impartial pathways for timely resolution of training-related disputes between trainees and supervisors or trainees and the organisation.
- 7.4.3 The training organisation has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
- 7.4.4 The training organisation has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Notes

Supervisors and their trainees have a particularly close relationship, which has special benefits, but which may also lead to unique problems. Trainees need clear advice on what they should do in the event of conflict with their supervisor or any other person intimately involved in their training. Clear statements concerning the supervisory relationship can avert problems for both trainees and supervisors.

Processes that allow problems to be addressed at an early stage will prevent complaints escalating to formal disputes.

Clear processes that allow trainees' difficulties to be addressed in a confidential manner will increase the trainees' confidence that the training organisation acts on their behalf, and will discourage arbitrary decision-making which is then subject to challenge. Trainees who experience difficulties often feel vulnerable in raising questions about their training, assessment or supervision, even anonymously, and can be concerned about being identified and potentially disadvantaged as a consequence. The same people often hold positions on training organisation committees and senior positions in hospitals and health services, which exacerbates these concerns and may lead to conflict of interest. Practical solutions are required to disincentives to trainees raising concerns, such as the timeliness of any review process, and the possibility that the training organisation may not count the disputed period of training towards training time.

Trainees may experience difficulties that are relevant both to their employment and their position as a trainee, such as training in an unsafe environment, sexual harassment or bullying. Whilst training organisations do not control the working environment, in setting standards for training and for professional practice, they have responsibilities to advocate for an appropriate training environment.

Having an appeals process that provides a fair and reasonable opportunity to challenge decisions taken by a training organisation is likely to ensure that decisions are ultimately correct. A strong process would have an appeals committee with some members who are external to the training organisation as well as impartial internal members. It would also provide grounds for appeal against decisions that are similar to the grounds for appealing administrative decisions in New Zealand.

In relation to decision-making conduct, the grounds for appeal would include matters such as:

- that an error in law or in due process occurred in the formulation of the original decision
- that relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision
- that irrelevant information was considered in the making of the original decision
- that procedures that were required by training organisation policies to be observed in connection with the making of the decision were not observed
- that the original decision was made for a purpose other than a purpose for which the power was conferred
- that the original decision was made in accordance with a rule or policy without regard to the merits of the particular case; and
- that the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

A strong appeals process also encourages procedural fairness, transparency and credibility, including requiring written reasons for decisions to be issued.

8 IMPLEMENTING THE TRAINING PROGRAMME – DELIVERY OF EDUCATIONAL RESOURCES

8.1 SUPERVISORS, ASSESSORS, TRAINERS AND MENTORS

8.1.1 The training provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the programme of study and the responsibilities of the training provider to these practitioners. It communicates its goals and objectives for specialist medical education to these practitioners.

8.1.2 The training provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training and professional development of supervisors and trainers.

8.1.3 The training provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees.

8.1.4 The training organisation has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.

8.1.5 The training organisation has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

Notes

Clinicians make significant contributions to medical education as teachers and role models for doctors in training. The roles of supervisor, assessor, trainer and mentor are critical to the success of the training programme, especially given the apprenticeship nature of specialist training. It is essential that there is adequate training and resources for these roles.

The Council has provided below some guidelines on these roles, but recognises that training organisations devise and implement their own structures in response to their specific goals and challenges.

A supervisor or director of training, who has overall responsibility for a training programme in a hospital or department, cannot normally be involved on a day-to-day basis with all trainees in the work environment. This is often the task of the trainer. Whilst a trainee is likely to be involved with a number of trainers during a single rotation, the supervisor or director of training should designate one trainer to have particular responsibility for appropriate hands-on supervision and training of an individual trainee and who has frequent involvement with the trainee during the week.

Supervisors/directors and trainers should have skills in adult learning, in providing constructive feedback to trainees, and in responding appropriately to concerns. They need clear guidance on their responsibilities to the trainee and to patient safety in the event that the trainee is experiencing difficulty, including in circumstances where a trainee is not maintaining a satisfactory standard of practice.

There are advantages for a trainee to have an ongoing relationship with a specialist in the discipline, who has no formal role in the assessment or employment of the trainee but who is available to the trainee for advice and support on personal or professional matters. This person, often termed a mentor, has responsibility to the trainee. Training organisations are encouraged to develop processes for supporting the professional development of doctors who demonstrate appropriate capability for the role of mentor.

There is value in liaison with relevant stakeholders⁵ concerning relevant professional development programmes when developing processes for supporting mentors.

Because of the critical nature of the roles outlined above, it is essential that there are clear procedures for trainees and supervisors to follow in the event of conflict. Accreditation standards in relation to the resolution of training-related problems and disputes are provided in section 7.4.

Assessors engaged in formative or summative assessments should understand the training organisation curriculum and training requirements, be proficient in the issues relating to the level of competence and training of the trainee, and skilled in providing feedback. Those assessing trainees should participate in education and training, addressing issues such as constructive feedback, dealing with difficult situations and different assessment methods.

⁵ Stakeholders may include Council, District Health Boards, Health Workforce New Zealand, the National Health Board, the Ministry of Health, the Minister of Health, the Health and Disability Commissioner, the Accident Compensation Corporation and other non government and community and consumer agencies in the health sector.

8.2 CLINICAL AND OTHER EDUCATIONAL RESOURCES

- 8.2.1 The training organisation has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.
- 8.2.2 The training organisation specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training programme. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.
- 8.2.3 The training organisation's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programmes, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.
- 8.2.4 The training organisation works with the health services and other stakeholders as previously defined to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

Notes

Most specialist education and training takes place in hospitals or in community-based health facilities such as general practices. The learning environment and the quality of the experience gained are thus of critical importance.

Training organisations define a range of experience to be gained during training. Training organisations should make as explicit as possible the training opportunities required of institutions seeking accreditation and any other expectations of them. Training organisation accreditation processes must verify that this experience is available in hospitals and community-based health facilities seeking accreditation.

During training, trainees are likely to gain experience in multiple locations each providing a varying range of clinical experiences. For this reason, training organisations are increasingly accrediting networks of training sites rather than single hospitals or other facilities. It is essential that training organisations have processes to ensure that the education, training and assessment at all sites satisfy the standards of the training organisation.

Depending on the discipline, an expanded range of settings would include private practice, rural placements and primary care settings.

The training organisation's accreditation processes must aim to ensure that trainees will gain all the required experience during their period of training. Where there are deficiencies, there must be processes to negotiate with the facility to overcome these.

It is acknowledged that some training settings may not meet every infrastructure requirement referred to in criterion 8.2.3. However the training organisation must demonstrate that trainees have access to appropriate facilities and educational resources to support self-learning activities as well as

structured educational programmes, whether these are accessed on-site or off-site. Access to library, journals, an electronic learning environment and other learning facilities are required to promote an ethos of life-time self-learning.

There is an expectation that trainees would contribute to the training of medical students, junior colleagues and relevant health professionals where appropriate.

9 CONTINUING PROFESSIONAL DEVELOPMENT

9.1 CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMMES

9.1.1 The training organisation's continuing professional development programme provides a process for maintaining and improving competence and performance comprising at least 50 hours each year and covering the Council's domains of competence, at least to the minimum requirements described in Appendix 3.

9.1.2 The training organisation determines the formal structure of the CPD programme in consultation with stakeholders.

9.1.3 The training organisation ensures that the process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.

9.1.4 The training organisation has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.

Notes

The community expects that registered medical practitioners will maintain and develop their knowledge, skills and performance so that they are equipped to deliver appropriate and safe medical health care over their working life.

Training organisations play an important role in assisting the professional development of their fellows and that of other specialists practising in their discipline.

9.2 RETRAINING

9.2.1 The training provider has processes to respond to requests for retraining of its fellows.

Notes

Requests for retraining may be made by fellows who have been absent from practice for a period of time, or by fellows who are seeking additional training in a discipline other than that for which the specialist qualification applies. The Council sets requirements concerning recency of practice and

assessment of practitioner proposals to change scopes of practice. Authorities may seek the assistance of specialist medical training providers in providing appropriate retraining.

9.3 REMEDIATION

9.3.1 The training organisation responds to requests for remediation of its fellows who have been identified as under-performing in a particular area.

9.3.2 The training organisation audits whether doctors are participating in the recertification programmes and whether they are meeting the requirements.

9.3.3 The training organisation reports to Council when requested those who are participating in the recertification programme and whether they are complying or not.

9.3.4 The training organisation has a system for identifying and managing compliance with recertification programmes, and where appropriate to refer the doctor to Council.

9.3.5 The training organisation informs Council if it becomes aware of performance or competence concerns on the part of the doctor.

Notes

As the result of complaints or for other reasons, training providers may be required to assist in providing remediation for specialists whose performance has been found to be unsatisfactory.

Appendix 1

Extracts from the Summary of the report **Trainee Selection in Australian Medical Colleges**
(from the 1998 MTRP annual report)
(Formatting follows the original document).

Recommended framework for selection of trainees

A clear statement of principles underpinning selection

- The aim is to select the best possible candidates;
- The objective is to produce the best possible practitioners;
- The process should be legal; and
- The process should be accountable.

Eligibility criteria/selection criteria

- There should be a clear statement of eligibility to apply for and be selected for training;
- Selection criteria should be documented and published; and
- Selection criteria must be objective and quantifiable.

Advertising

- There is to be national awareness of opportunity for all eligible candidates.

Limits to the numbers of training positions

- If there is a quota it should be explicit and openly declared; and
- All limits relating to other factors such as the number of training positions should also be disclosed.

Applications for training positions and use of references

- All applications should be written using a standardised proforma; and
- Referees' reports should also be written using a standardised pro-forma with a view to achieving objectivity, comparability and quantification.

The selection committee

- The group making the final decision should have the confidence of the candidate, the profession and the community;
- The size of the committee should be proportional to the task;
- Committee members should be prepared to be held accountable for their decisions and for their processes to be reviewed in other forums; and
- The selection process itself should be valid, reliable and feasible with built-in evaluation.

Conduct of the interview (selection, ranking, documentation and feedback)

- The interview should be objective and free from bias;
- The selection through interview must be based on the published criteria and the principles of the college concerned and should be capable of standing external scrutiny; selection committees should rank and score candidates using the tools described;
- A record of proceedings should be kept in sufficient detail to allow non-participants to reconstruct the interview processes and decisions. This documentation should be made available where appropriate for the purposes of audit, external scrutiny and evaluation of the selection process; and
- All candidates should be given an honest and frank appraisal of their standing from the selection committee.

Appeals and evaluation

- Applicants should have the right to a formal process to appeal and review decisions by an internal and external committee if they disagree with the process or outcome of the original selection committee;
- Candidates have the right to be free from any future bias if they choose to seek review or appeal although they may be required to cover the expense of an external review should the appeal be unsuccessful; and
- Colleges should have sufficient confidence in their selection process to recognise appeals as part of an accountable system and should be prepared to meet the costs of an external appeal where their processes are found wanting.

Appendix 2

DEFINITION OF CULTURAL COMPETENCE.

Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this.

The full Statement on Cultural Competence is at:

<http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf>

Appendix 3

CONTINUING PROFESSIONAL DEVELOPMENT (CPD) TO MEET MEDICAL COUNCIL REQUIREMENTS FOR RECERTIFICATION.

The following elements need to be defined:

- The categories of doctors and the number of doctors undertaking their recertification programme.
- Any categories of doctors that are not enrolled in a recertification programmes.
- Confirmation that the recertification programme is available for all doctors registered within a vocational scope of practice who are non-members (ie, not trainees nor Fellows).
- Details of the hours per year required to be spent on recertification activities and how that is comprised.
- Details of the process that is in place for evaluating whether doctors participating in the programme are meeting the requirements.
- Whether the education provider collects information about:
 - the numbers of and outcomes for doctors who undertake regular practice reviews
 - whether their doctors have undertaken a credentialing process and if so whether there are checks in place to ensure those doctors are doing CPD appropriate for their clinical responsibilities.
- How the education provider accounts for cultural competence and identifies formal components of the recertification programme that contributes to the cultural competence of recertification programme participants. (Please refer to the additional information provided about cultural competence under standard 4.2).

The recertification programme must provide a process for maintaining and improving competence and performance (at least 50 hours per year) and should cover the Council's domains of competence:

- Clinical expertise.
- Communication.
- Collaboration.
- Management.
- Scholarship.
- Professional attributes.

CPD programmes must include: (see Notes for definitions)

- Medical Audit.
- Peer Review.
- Continuing Medical Education

CPD programmes may include:

- Examining candidates for College examinations.
- Supervision, mentoring others.
- Teaching.
- Publications in medical journals and texts.
- Research.
- Committee meetings that have an educational content, such as guideline or policy development.
- Providing expert advice on clinical matters.
- Presentations to scientific meetings
- Working for the Council as an assessor or reviewer
- Regular practice review.

Notes

If the education provider seeking reaccreditation is not the direct provider of the recertification programme in New Zealand then evidence is required that the New Zealand provider meets these requirements.

Definitions:

1. Medical Audit (at least one audit per year)

This is a systematic, critical analysis of the quality of the doctor's own practice that is used to improve clinical care and/or health outcomes, or to confirm that current management is consistent with the current available evidence or established guidelines.

CRITERIA

1. The topic for the audit relates to an area of the doctor's practice that may be improved.
2. Undertaking the process will not unjustifiably compromise other aspects of health service delivery.
3. An established standard is used to measure current performance.
4. An appropriate written plan is documented.
5. Outcomes of the audit are documented and discussed.
6. Where appropriate, an action plan is developed that identifies the benefit of the process to patient outcomes. The plan should outline how the actions will be implemented and a process of monitoring.
7. Subsequent audit cycles are planned, where required, so that the audit is part of continuous quality improvement.

Examples of audit of medical practice are:

- external audit of procedures (not of the service);
- comparing the processes or outcomes of care for a service with what is judged to be best practice in the particular domain;
- analysis of patient outcomes;
- audit of departmental outcomes with information on where individuals fit within the team as a whole;
- audit of an doctor's performance in an area of practice against his or her peers;
- taking an aspect of practice such as prescribing habits and comparing an individual's performance to national standards;
- formal double reading of scans or slides and assessment of an individual's results against those of the group;
- patient satisfaction survey;
- checking that cervical smear, diabetes, asthma, heart failure, lipid control and other procedures are done to pre-approved standard formats, including reflection on the outcome, plans for change and follow-up audit to check for health gains for that patient or for that group of patients;

2. Peer review (a minimum of 10 hours per year)

This is an evaluation of the performance of individuals or groups of doctors by members of the same profession or team. It may be formal or informal and can include any occasion in which doctors are in learning situations about their own practice with other colleagues. Peer review can also be used in

the context of multidisciplinary teams which incorporate feedback from 'peers' or other health professionals who are members of the team.

Formal peer review is an activity where peer(s) systematically review aspects of a doctor's work, eg, a review of the first six cases seen or a presentation on a given topic. It would normally include guidance, feedback and a critique of the doctor's performance.

Peer review must take place in an environment conducive to:

- the confidentiality of the patients being discussed
- the privacy of the doctors whose work is being reviewed
- mutual learning
- professional support and collegiality.

Peer review includes, for example:

- joint review of cases
- review of charts
- practice visits to review the doctor's performance
- 360° appraisals and feedback
- critique of a video review of consultations by peer(s)
- peer discussion groups
- inter-departmental meetings which may review missed cases and interpretations of findings
- mortality and morbidity meetings.

For those in clinical (rather than non-clinical) practice peer review does not include:

- Practice management.
- Matters relating to practice premises or systems.
- Non-clinical research.
- Non-clinical education.
- Participation on College or other committees that are not of a clinical nature.

3. Continuing Medical Education (a minimum of 20 hours per year)

Includes attendance at appropriate:

- education conferences, courses and workshops
- self-directed learning programmes and learning diaries
- assessments designed to identify learning needs in areas such as procedural skills, diagnostic skills or knowledge
- journal reading.

4. Competence – is defined as whether a doctor has the attitude and knowledge and skills to practise medicine in accordance with his or her registration and meets the reasonable standard expected of a medical doctor with his or her level of registration.

5. Regular practice review (RPR)

Regular practice review is a formative assessment to help individual doctors identify areas where aspects of their performance could be improved, benefiting not only their own professional development but also the quality of care that their patients receive.

The key principles of RPR include, but are not limited to;

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- That RPR is a formative process. It is a supportive and collegial review of a doctor's practice by peers, in a doctor's usual practice setting.
 - That the primary purpose of RPR is to help maintain and improve the standards of the profession. RPR is a quality improvement process. RPR may also assist in the identification of poor performance which may adversely affect patient care.
 - That RPR provides an assessment across the domains of competence outlined in *Good Medical Practice* focusing on the area in which the doctor works.
 - That RPR is supported by a portfolio of information provided by the doctor, which may include audit outcomes and logbooks.
 - That multi source assessment forms part of a RPR.
 - That RPR must include some component of external assessment, by peers who are not part of the doctor's usual practice setting.