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By email: SConsultation@mcnz.org.nz

Dear Carol

Discussion document on strengthening recertification for vocationally registered doctors

Thank you for the opportunity to provide feedback on the above consultation. As you will know, the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine (FPM), is responsible for the training and examination of anaesthetists and pain medicine specialists and for the standards of clinical practice in New Zealand and Australia. ANZCA's mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.

ANZCA is generally supportive of the proposed approach to recertification outlined in the Council's discussion document. We appreciate that the Council sought and acted on feedback from vocational bodies to develop appropriate and well thought-out guidance. The key components of the proposed approach now provide an enlightened approach to recertification across a broad spectrum of medical specialities.

We agree that recertification should not create duplication of processes. The Council of Medical College's publication, *Best Practice Guide for Continuous Improvement (New Zealand)*, remains relevant. The aim of the guide was to create a framework so duplication of performance appraisals effort could be avoided.

Our feedback on the "questions to consider" is provided below.

1. **What are your thoughts about the key components of the proposed strengthened recertification approach?**

The key components of the proposed approach are sensible and reflect a pragmatic, real-world approach to addressing the range of scopes of practice in medicine. It is refreshing to see the focus on evidence-based activities rather than a time-based credit system.

The proposed framework seeks to capture what most doctors do as part of normal activity during their professional careers and it should not be overly onerous to

achieve. We support the requirement for an enhanced professional development plan (PDP) as many doctors currently do not have a long term pathway for their career.

ANZCA supports the proposal that recertification programmes are tailored to individual doctors' workplace activities. As such, a needs analysis by individual doctors could inform a structured plan composed of specific activities to address those needs under the four pillars of patient engagement - clinical effectiveness, engagement, quality improvement and patient safety.

Encouraging clinicians to assume responsibility is in-line with the attitude to learning that ANZCA fosters amongst trainees in anaesthesia with our training portfolio system (TPS). Continuation of this as a professional behaviour and approach to life-long learning is congruent.

ANZCA also supports the proposal of long(er) term planning and the recognition that individuals' needs change throughout their careers and life-stages.

Many colleges have substantially implemented some or all of the key components, which have been signalled in previous drafts or guidelines from the Council. When referencing the components to the ANZCA and FPM CPD programme, it is clear that we have already achieved most of the goals. For example:

- Specific to scope, including the emergency response activities that are unique.
- Evidence-based, with weighting for the mandatory activities in the practice evaluation category and discrete allocation of fixed credits for key activities.
- Relevant to actual workplace, both in practice through practice review and simulator training, through patient surveys and multisource feedback (MSF), and the emergency response activities.
- Offers regular performance review (RPR), as defined by the Council, with both mandatory and non-mandatory activities.
- Offers non time-based activities, such as the mandatory activities in both the practice evaluation and emergency response categories.
- Planning function mandatory. Although it requires some strengthening, this should be relatively straightforward to achieve.

What suggestions do you have about how these key components could be implemented in recertification programmes?

Vocational bodies will need to clearly define the scope of practice of their practitioners and then create a programme that reflects that scope and meets the requirements of the key components.

They will need to ensure that the focus of the programme relates to the activities that their doctors do already and not to create a burdensome body of work over and above that. The paragraph around "recertification in context" on page 9 of the discussion document is particularly relevant in this regard.

ANZCA suggests that the Council may need to provide some resources to help doctors develop tailored, specific, measurable plans.

It may be that some of the vocational bodies could provide advice or mentorship to others, if required.

2. **Do you foresee any challenges with implementing the proposed approach? What are these and why?**

While ANZCA supports the proposal for RPR and has already incorporated it into our CPD programme, it would be prohibitively expensive to expect or require the peer reviewers to be

external to the doctors' normal workplaces. In addition, using external reviewers is not consistent with the formative and “therapeutic" principles underpinning regular peer review: that is, learners/practitioners are more likely to respond favourably to constructive feedback and act upon it when it is provided as part of a trusted collegial relationship.

Proposal 6 (Specified CPD hours and type) is consistent with the move to competency-based medical education programmes and the acknowledgement that life-long learning is essential for all doctors' medical careers. However, the logistics for vocational bodies of developing and overseeing recertification programmes that are not composed of some time-based activities would be difficult. The ANZCA CPD allows a flexible approach to learning with a three-year cycle.

For some vocational bodies, implementation will be relatively straightforward as they are already substantially compliant with the key components of the proposal. For others, it will be a challenge to provide leadership and guidance to their practitioners without alienating them in the process.

Our experience at ANZCA is that, with time, the vast majority of doctors recognise that a profession-led solution is the best solution. Doctors become compliant and proficient at capturing professional activities for their portfolio. In fact, many now enjoy the experience of practice review and other activities that enhance their practice. Another factor is that younger doctors are quite used to being formatively assessed and regard it as part of normal activity, in contrast to their more senior peers.

3. **Are there any specific implementation concerns for recertification programme providers (in most cases these are medical colleges)? Do you have any suggestions about how these issues could be resolved?**

Proposal 5 (Offering regular practice review (RPR)) implies that vocational bodies should be responsible for the components of RPR. ANZCA believes that colleges can provide resources to support RPR activities, such as structured frameworks and guidance for reviewers about providing actionable feedback, or facilitate the process by developing a list of specialists available to provide RPR to rural or remote practitioners. However, we consider that it is the responsibility of individual doctors to make the arrangements.

4. **Do you think there are any recertification activities that should be mandatory for all doctors?**

There are few activities that are relevant to all doctors. In our view, vocational bodies are best placed to make decisions about whether participation and completion of specific mandatory activities is essential for doctors within that specialty, for example the ANZCA emergency response activities.

The Council decided many years ago that clinical audit should be mandatory on a yearly basis. While audit is a key component of assessment of practice effectiveness, ANZCA considers that it may not be necessary to complete a yearly audit and it may well debase the value of clinical audit. Nevertheless, many vocational bodies have audit as a key activity in their CPD programmes, and it is one of the four mandatory activities in the ANZCA and FPM CPD programme

The Council may wish to consider the model of clinical audit that would be most effective for differing scopes of practice, but ANZCA appreciates that the proposed approach leaves interpretation open to vocational bodies to determine. The current ANZCA CPD standard allows for differing models of audit (individual, group, multidisciplinary, registry data, etc.).

Multi-source feedback (MSF) has an evidential base and ANZCA suggests that it should probably be a mandatory activity. Practice or peer review should also be mandatory.

The debate will be around the implementation of these activities and the necessary frequency. Solo or remote practitioners find it challenging to engage suitable assessors and it is relatively onerous for them to organise, compared to group or public hospital practice doctors. However, the NZ Orthopaedic Association has instituted a very successful practice review programme so it can be done.

There are other scope-specific activities that should be mandatory for interventional doctors, such as cardiac resuscitation. ANZCA has very successfully introduced these types of mandatory activities into its CPD programme. Another example of a discrete activity might be management of acute behavioural disturbance for emergency physicians or psychiatrists (now included as an emergency response in the ANZCA and FPM CPD programme).

The ANZCA and FPM CPD committee is currently reviewing the prioritisation of two further activities - cultural competence and doctor welfare. Cultural competence is already included in the portfolio, but the intent is to strengthen its importance and include it in the practice evaluation category of the portfolio. The question around the need for mandatory status is also being debated. Similarly, the committee is considering the addition of a doctor welfare activity and is awaiting advice on this from the Welfare Special Interest Group of the College.

5. **What kind of peer review programmes might work best for you/your organisation? Do you foresee any issues for recertification providers to offer RPR as an option for doctors?**

As noted above, ANZCA considers that the most valuable feedback during RPR activities will be from other trusted specialists familiar with the doctors' workplace, their roles and responsibilities, and able to give specific feedback and facilitate the development of action/recertification plans. There may need to be some training of doctors to fulfil these requirements (for example, online modules) and an expectation that employers will facilitate and support the process, as it ensures a more competent workforce overall.

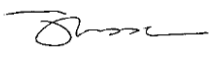
ANZCA now has a mature CPD programme that has a very high compliance rate (>99.6% across Australia and New Zealand) and a high acceptance rate among its fellows (>80% rate the programme favourably for relevance and usability). The ANZCA and FPM CPD committee is about to commence a five-year review of the programme that will take cogniscence of the Council's proposals and also the Professional Performance Framework proposed by the Medical Board of Australia. It is pleasing to see that the two organisations are closely aligned on this issue.

6. **Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?**

ANZCA suggests that professional bodies should determine how RPRs should be managed (internal vs external reviewers) because it will be expensive if they want only external reviewers.

Thank you once again for the opportunity to provide feedback. If you have any questions or would like to discuss this submission, please contact Mary Harvey (Senior Policy Adviser) in the first instance on 04 495 9780 or at mharvey@anzca.org.nz.

Yours sincerely



Dr Jennifer Woods
Chair, New Zealand National Committee