



Te Kaunihera Rata
o Aotearoa

**Medical Council
of New Zealand**

STRENGTHENING RECERTIFICATION FOR VOCATIONALLY-REGISTERED DOCTORS IN NEW ZEALAND

A DISCUSSION DOCUMENT

September 2018

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What is recertification?

Recertification is the regular and ongoing process by which doctors in New Zealand demonstrate that they are up to date. Recertification supports doctors to take responsibility for their own performance and to stay current in their practice. Recertification drives improvement, builds on the already high standard of medical practice and provides confidence and assurance to patients about their doctor. Recertification focuses on clinical competence as well as professionalism, ethics and communication with patients.

There is a growing focus on patient safety and the public increasingly expect and demand safe, high quality care. There is also a need for greater transparency in the governance of the care provided by the health system and doctors. There is a corresponding increasing drive for accountability.

The public in New Zealand has a high level of trust in doctors and they expect that a good level of care will be provided to patients. We need to provide assurance to the public that the trust in doctors is warranted.

Similar systems are in place and being developed internationally. The Medical Board of Australia is developing a Professional Performance Framework and the United Kingdom has a system of revalidation. Other similarly named systems are being developed in a number of other international jurisdictions, including the United States of America and Canada.

The concepts are not identical and the way that recertification and revalidation work in each jurisdiction differs. However there is commonality across all jurisdictions in that the overarching goal is to provide assurance of the competence of doctors, support the maintenance of high standards of practice and strengthen accountability to the public.

While reforms focused on developing and implementing recertification were commenced by some medical regulators over 10 years ago, this continues to be an area in which 'good' or 'best' practice is still emerging. There remains a significant lack of agreement about the design and form that it should take, hence medical regulators continue to grapple with a range of approaches, reviewing, evaluating and refining models in a continuous fashion, as greater understanding occurs and new research emerges.

Recertification in New Zealand

As the regulator of the medical profession, the Medical Council of New Zealand (the Council) plays a key role to ensure public safety and to assure and maintain public trust and confidence in the profession; including that doctors continue to maintain high standards of competence.

As part of its responsibility, the Council has a formal role in setting recertification programmes for all doctors in practice.

A key aspect of recertification is that it is both a quality assurance and quality improvement process: quality assurance in that it needs to meet the Council requirements to assure the public; and quality improvement to support doctors to improve the standard of care for their patients. The intention is that recertification processes are "therapeutic" not "diagnostic".

Recertification requirements support doctors to maintain their competence. This is more likely to occur if the doctor reflects on their practice and utilises this to determine their learning requirements. Active and effective participation in accredited recertification programmes provides assurance that a doctor is

competent and up to date with best practice. These principles are at the heart of the Council's approach to recertification.

In seeking to strengthen recertification programmes, the Council's primary focus is on the protection of the public. Any changes need the support of the medical profession, employers and medical colleges in order to be implemented effectively. Our model of 'self-regulation' and approach to recertification is that it needs to be profession-led.

The needs of the public and those of the medical profession need to be balanced in determining what regulatory levers should be put in place to best deliver assurance to the public about the quality and safety of doctors. Changes should be focused on strengthening accountability to the public, providing transparency (to the profession and the public) and be efficient and effective.

We will provide the evidence base for change. It is our intention to engage with the profession, medical colleges, employers and other stakeholders to gain key input into the design.

It is also important that any change does not create additional administrative burden, duplication of processes or added layers of bureaucracy for doctors. Therefore engagement and participation of the profession and stakeholders is essential when considering options.

Current recertification requirements

The current requirements for vocationally registered doctors are that they must participate in an accredited recertification programme appropriate to their scope of practice.

As a general rule, Council requires doctors, as part of their approved recertification programmes, to undertake 50 hours of professional activity each year, directed to the maintenance of competence. Competence is defined as the knowledge, skills and judgement to a standard reasonably expected of a doctor practising medicine in their scope of practice.

These 50 required hours should include:

- participation in audit of medical practice (at least one audit per year)
- peer review (a minimum of 10 hours per year)
- continuing medical education (a minimum of 20 hours per year).

More details about current recertification requirements can be found on the Council's website [here](#).

The current requirements were put in place about 20 years ago, when there was little evidence available to support the approach chosen and these have largely remained unchanged from a time-based, rather than an evidence-based, model.

Background

In March 2015, the Council considered the requirements for recertification for vocationally-registered doctors in New Zealand. A document setting out a proposed vision and principles for recertification was published for consultation, and to promote debate and discussion with stakeholders and the wider health sector. After considering feedback from the consultation, the Council set the *Vision and Principles for Recertification*, which were published in February 2016 and are as follows:

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 maintenance of high standards and 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 Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations 1996 under the Health and Disability Act 1994.*
- *Supported by employers.*

1. **Recertification is evidence-based**

There needs to be evidence supporting any recertification activity. Where evidence shows there is a minimal relationship between an activity and a goal (for example ensuring standards are achieved; improving quality) the activity should not form a major component of recertification. Conversely where evidence does demonstrate a strong relationship, the activity should form a major component.

New initiatives or innovations, by their very nature, will not be evidence-based. Persons or organisations designing and implementing new initiatives or innovations have an obligation to evaluate the relationship between the initiative or innovation and a goal.

Activities should be aimed at improving performance in practice.

2. **Recertification is formative in nature**

Recertification activities are formative. Doctors may participate in activities in which they receive feedback to guide their individual education and CPD. The feedback is not aimed at judging whether the doctor is performing at the required standard of competence. Recertification differs in this regard to other activities such as credentialing, exams or tests that are summative in nature.

3. **Recertification is informed by relevant data**

Good quality performance and outcome data should form a central component of recertification. Data will inform doctors about their performance and provide guidance on the areas to focus on in their CPD activities.

The Council's Promoting Competence strategic direction and its policy on recertification is based on doctors receiving information and feedback on their performance, including areas for improvement in their practice. Better data is important to this process.

4. *Recertification is based in the doctor's actual work and workplace setting*

Recertification should focus on improving the practice of doctors relevant to their specific practice and the health service setting in which they work.

Recertification and CPD should focus on skills, knowledge and attributes relevant to standards of safety and quality in the areas of:

- Professionalism.
- Communication.
- Cultural competence
- Clinical management.
- Clinical problems and conditions.
- Procedures and interventions.

5. *Recertification is profession-led*

Recertification should be profession-led. Establishing standards and ensuring individual commitment should be the role of the medical colleges and other appropriate educational organisations. The required standard of quality must reflect expected standards of medical practice. The leadership of the profession is critical. Recertification is based on doctors receiving feedback, within an open and supportive culture. It 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.

6. *Recertification should be informed by public input and referenced to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations 1996 under the Health and Disability Act 1994*

Standards of quality for practice should be developed in discussion with consumers and should reflect the Code of Consumers' Rights and the expectations of doctors.

The Health and Disability Commissioner's *Code of Health and Disability Services Consumers' Rights Regulations 1996* under the *Health and Disability Act 1994* imposes legal duties on doctors that are relevant to all areas of medical practice, particularly professionalism and communication. Consequently they must form part of the standard of quality for practise.

7. *Recertification should be supported by employers*

For doctors who are employees, their employer has a responsibility to support and invest in the recertification and CPD of their employee doctors.

Sector feedback on a proposed strengthened approach

Feedback from the consultation on the vision and principles for recertification indicated a need for the Council to provide further guidance about how medical colleges could develop their recertification programmes to align with the vision and principles.

The Council reviewed the requirements for vocationally registered doctors and developed a straw-man proposal for a strengthened approach towards recertification programmes that aligned with the vision and principles. Sector feedback was sought on the proposal during a consultation process held in early 2017.

There was high interest in the consultation and the Council received 148 submissions, including 42 from organisations and groups and 106 from individual doctors. The group responses included submissions from medical colleges, employers, unions, associations representing medical professionals, primary health organisations and other medical regulators.

What did you tell us?

Generally the submissions were supportive of some of the key elements of the proposal, including the need for all doctors to have an individualised Professional Development Plan (PDP) that was updated annually; that colleges offer Regular Practice Review (RPR) as an option to their doctors; and the use of Multisource Feedback (MSF) as a tool to gather data that informs professional development activities.

Some of the other points raised included the need for clarity about where data might be sourced to inform the PDP, career development and planning; and the need to ensure that any changes proposed were mindful of approaches being considered by the Medical Board of Australia (MBA) – this was particularly pertinent for Australasian medical colleges.

Some submitters also sought clarity around implementation considerations, particularly around the timeframe for colleges to meet requirements.

After considering the feedback, the Council decided to take a measured approach and look more closely at the issues raised, along with talking further with stakeholders, before taking any next steps.

In order to inform the Council's thinking, a Recertification Working Group of the Council and stakeholder experts was established to consider all of the feedback received and also look at the evidence around the value of particular recertification activities.

Evidence to support change

There are limits to the current recertification model as it relies on completion of continuing professional development (CPD) as its key mechanism. Completion of CPD does not necessarily demonstrate competence and there needs to be a greater focus on the effectiveness of recertification activities on performance and competence in order to provide a greater assurance of the competence of doctors to the public.

The Council has published a [literature review](#) of the evidence relating to recertification activities. In summary, for the purposes of this paper, international evidence suggests there are several key elements to delivering and receiving effective education and professional development. Research undertaken on the efficacy of particular activities, highlights those that provide the greatest value – in terms of both for the doctor and for patient outcomes.

- ***Education about and at the workplace***

Education should reflect and be based on the real needs of the doctor's work – the environment they work in, and the nature of their scope of practice – rather than theoretical concepts. There are proven effective learning opportunities in activities such as undertaking multisource feedback amongst colleagues; and undertaking regular practice review in the doctor's usual working environment.

- ***Continuing medical education (CME)***

The right kind of CME is effective in improving a doctor's knowledge and skills, providing they learn things in areas where there is an identified need – not where they are already adept. A meaningful and appropriate professional development plan that is informed by data from the doctor's practice can be a helpful tool to highlight where there are opportunities for further learning that will be of real benefit to the doctor and their patients.

- ***Educational approach***

The way in which education is presented to the doctor is key to how effective it can be. Related to this is ensuring educational opportunities are regularly offered to doctors through a range of mechanisms. This might include reminders sent about the availability of suitable courses, information on how and where to access data to inform learning and professional development planning, and the ability to undertake activities that might be utilised to meet multiple requirements (e.g. recertification, annual appraisal, credentialling).

- ***Effective delivery***

Choosing the most effective methods to deliver educational opportunities is important to how successful the educational experience is. Evidence shows that interactive educational sessions, peer review and audit are more likely than other activities to lead to practice change and improvements in patient outcomes.

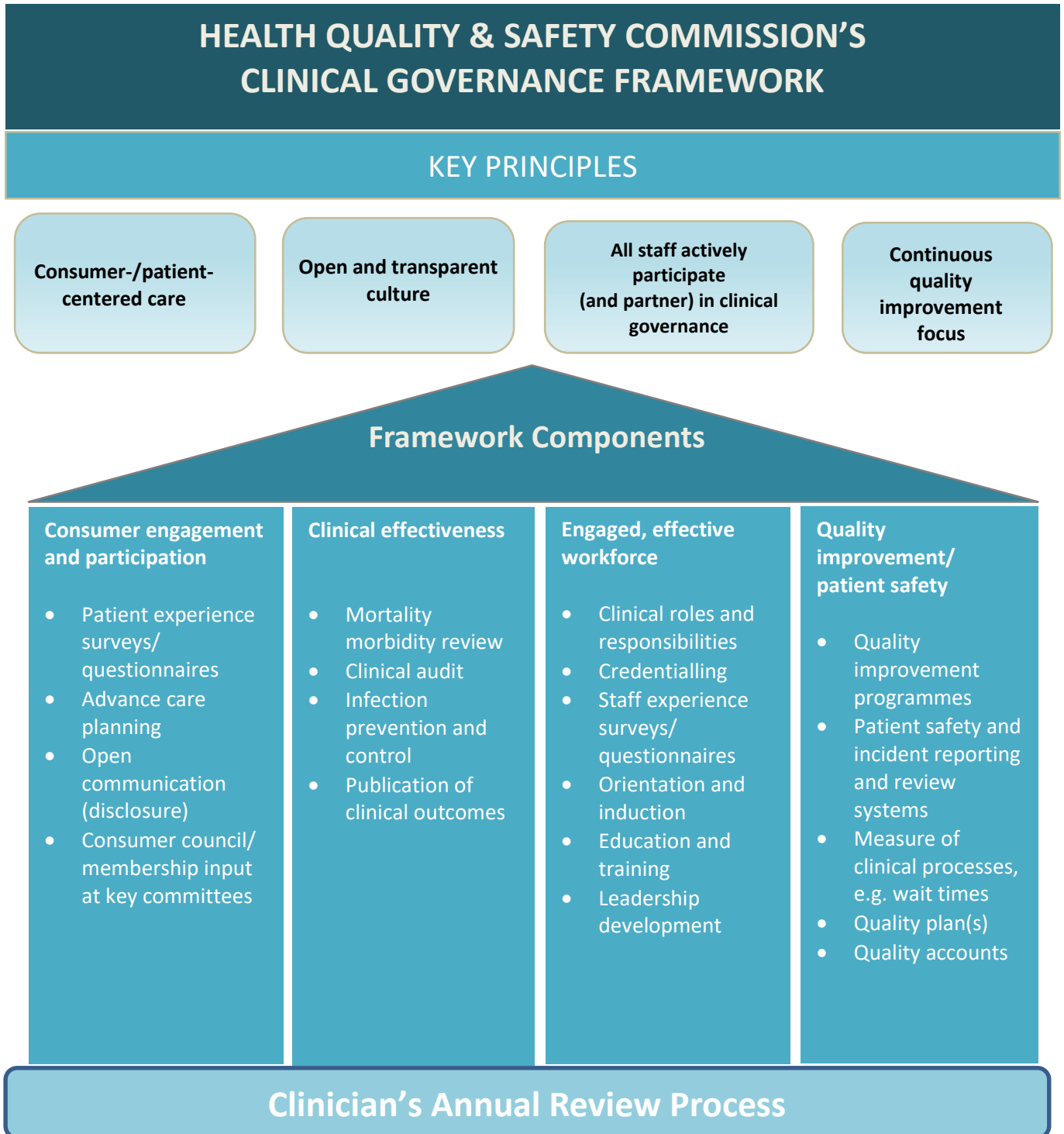
- ***Learning information technology***

New technology can be utilised to allow for faster, more flexible and timely educational opportunities. Advancements in global connectivity via virtual mechanisms provide greater opportunities than ever before for learning in an international best practice environment.

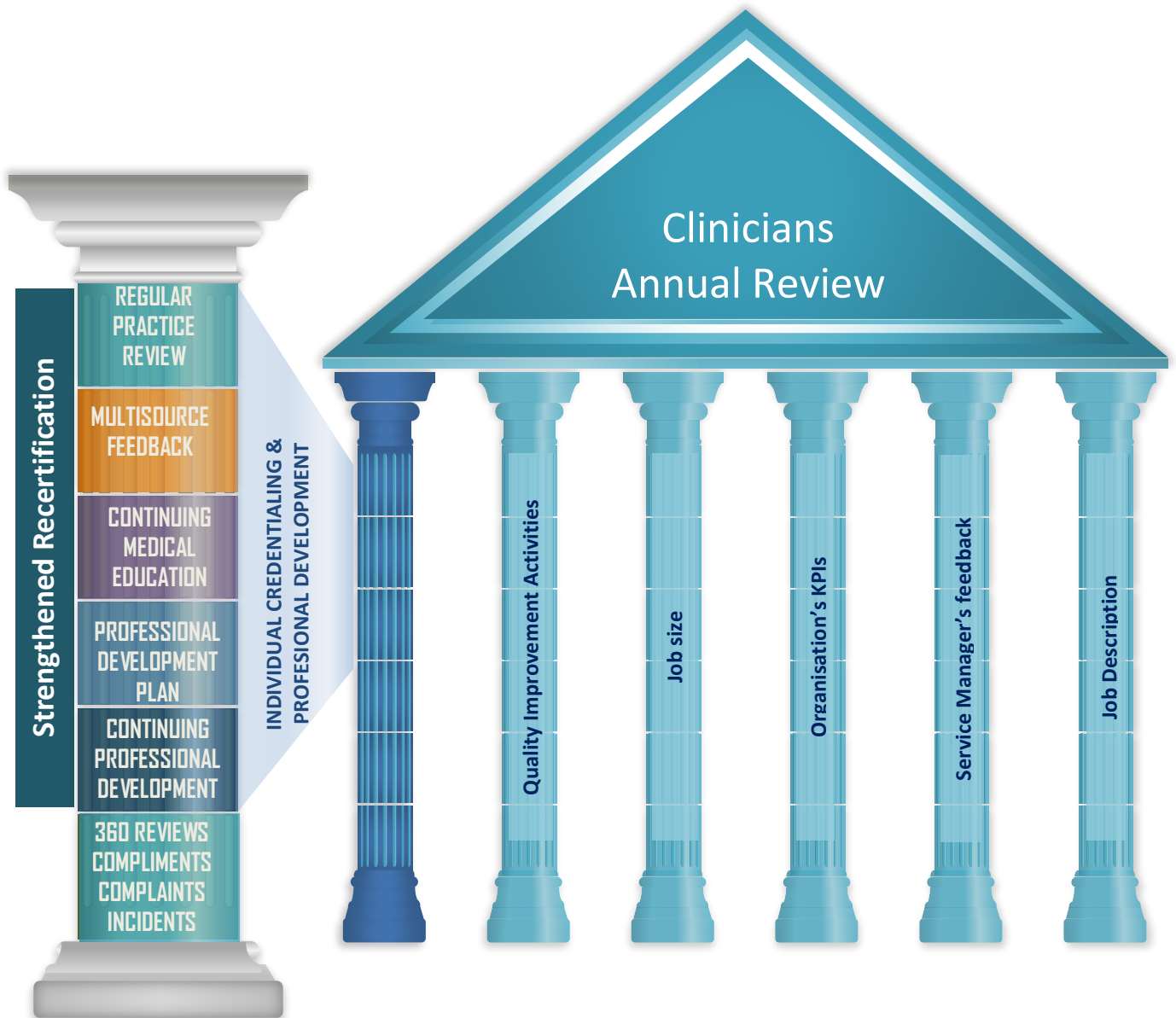
Recertification in context

Recertification should be considered in context with other processes in order to reduce duplication and refine data capture, allowing data (where appropriate) to be collected once, but used for multiple purposes – especially when these processes all take place in the doctor’s workplace.

The diagram below has been developed based on the Health Quality & Safety Commission’s guidance on clinical governance frameworks (*Clinical Governance: Guidance for health and disability providers (2017)*) to provide context with professional development, credentialling and the clinician’s annual review process.



This diagram shows where recertification sits in relation to other processes and activities.



Key components of effective recertification programmes should be that activities are based on evidence of best practice, they are appropriate and that they provide effective education and development opportunities.

The Council has therefore proposed the following core components as a basis of a strengthened approach to recertification. These are:

- *A profession-led approach, appropriate to scope of practice.*
- *Increased emphasis on evidence, value of activities & peer review.*
- *Education and development relevant to workplace and career planning.*
- *Use of a professional development plan (PDP) to guide learning.*
- *Offering regular practice review.*
- *Specified CPD hours and type.*

To provide guidance and suggestions on how this could be implemented, the Council has provided some further detail below on these key components.

1. A profession-led approach, appropriate to scope of practice

Activities should be relevant to the doctor's scope of practice and therefore the decision about what these should be must sit with the relevant recertification programme provider – in most cases in New Zealand, this is the medical colleges.

Doctors also need to be able to map their CPD activity to their scope of practice – usually by reference to their college curriculum. A profession-led approach is integral to ensuring recertification activities are appropriate, meaningful and add value to a doctor's practice and professional development.

Proposal:

When developing recertification programmes, providers determine what the most relevant and valuable activities are for their scope of practice.

2. Increased emphasis on evidence, value of activities & peer review

International evidence indicates that the most effective education programmes are considerate of the method in which these are delivered, are interactive and are informed by multiple data sources.

There is significant value in audit (done well), multisource feedback from a range of sources, and peer review of a doctor's actual practice.

Proposal:

Recertification programmes are based on evidence and utilising data that informs what the most valuable activities are for the doctor.

3. *Education and development relevant to workplace and career planning*

The value of activities is only realised as long as these are based on the doctor's real work, in their usual practice setting. Education programmes and learning activities should be focused on areas identified as needing development to ensure these add value and can lead to improvements (where appropriate) in the doctor's practice.

Activities should also be considerate of the doctor's career planning objectives to ensure they are meaningful and appropriate.

Proposal:

Recertification programmes are relevant to the doctor's actual workplace and career plans.

4. *Use of a professional development plan (PDP) to guide learning*

Sources to inform PDPs could include:

- peer review
- regular practice review
- multisource feedback
- audit findings
- practice data
- employer processes (e.g. credentialling, clinician annual review)
- career path and planning across the progression of the doctor's career.

Proposal:

Recertification programmes include use of a PDP to guide learning and development.

5. *Offering regular practice review (RPR)*

Council introduced RPR as a component of the *Inpractice* Recertification programme for generally-registered doctors in 2013. An evaluation programme has since been implemented, which has gathered evidence on the efficacy of RPR. You can read independent evaluator Malatest International's [evaluation reports on Council's website](#).

For vocationally-registered doctors, the intention would be for recertification programme providers to offer regular practice review as an option to doctors. This could potentially be incentivised by allowing RPR to count towards all the activities/requirements for the year in which it occurs – but this would have to be limited so this option could be used only periodically, perhaps once in every three years.

Proposal:

All providers offer RPR as an option in recertification programmes for their doctors.

6. *Specified CPD hours and type*

The number of CPD hours and the type of CPD would need to be strongly influenced by the evidence and what was appropriate to the doctor's scope of practice. The required activities are a matter for providers to consider, however Council would expect recertification programmes to place a greater emphasis on the value and benefit – with evidence of reflective practice – to the individual doctor (and patient outcomes), rather than a time-based approach.

So perhaps a programme could look something like this:

1. A percentage of peer review and audit – activities such as RPR and multisource feedback could count towards this. Some activities might be given greater weighting than others, depending on their value to enhancing the doctor’s practice.
2. A percentage of CME – based on identified areas of learning need, as outlined in the PDP.
3. Essentials knowledge: Medical Council of New Zealand’s *Good Medical Practice* and statements; NZMA *Code of Ethics*; the Health and Disability Commissioner’s *Code of Health and Disability Services Consumers’ Rights* Regulations 1996 under the *Health and Disability Act 1994*; *Health Practitioners Competence Assurance Act (2003)*; *Health Information Privacy Code (1994)*.

The above approach is only a suggestion to provoke thought and discussion; Council would not stipulate how recertification programmes should be structured.

Proposal:

Providers develop recertification programmes using an evidence-based, rather than a time-based approach, that is appropriate to the doctor’s scope of practice. This could include components such as peer review and audit, CME and knowledge-based activities.

A flexible approach

Recertification programme providers would have flexibility to decide and develop appropriate programmes for their professional scope.

Some aspects to consider could include:

- What would audit look like for this group of doctors?
 - What should inform and/or be included in the PDP?
 - What is appropriate for the doctor’s practice setting?
 - What combinations or percentage of CPD activities are of most value to members and how can this be accessed?
 - What would RPR include/involve?
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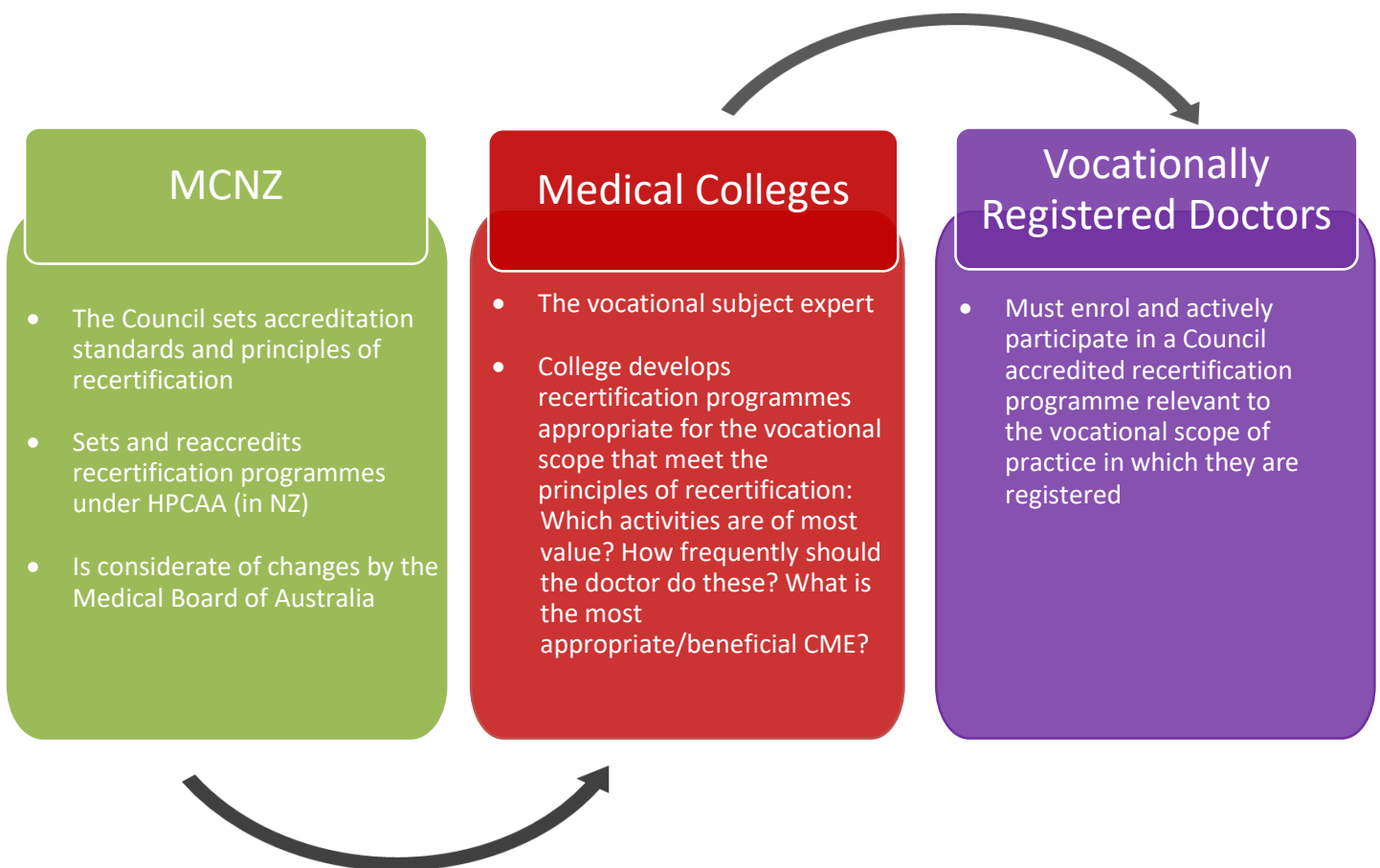
Roles and responsibilities

An effective approach relies on the expertise, knowledge and participation of all involved in recertification processes – but while also continuing to embrace a high trust model. We all have a role to play to ensure vocationally registered doctors are engaged in their learning, professional development and career planning; the Council, the colleges and doctors themselves.

These separate but linked roles are shown in the model below:

A High Trust Model

Medical Council of New Zealand/Australian Medical Council accredit colleges (providers) to deliver recertification programmes



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Questions to consider

1. What are your thoughts about the key components of the proposed strengthened recertification approach?
 2. What suggestions do you have about how these key components could be implemented in recertification programmes?
 3. Do you foresee any challenges with implementing the proposed approach? What are these and why?
 4. 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?
 5. Do you think there are any recertification activities that should be mandatory for all doctors?
 6. 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?
 7. Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?
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Submitting your feedback

You may submit your feedback to this discussion document by using the online pre-populated question and answer form and submitting this through the link provided.

You may also provide comment via email to:

To: Carol Parreno - Strategic Project Manager

Email: SConsultation@mcnz.org.nz

The Council will also be collecting feedback throughout August and September via a range of meetings, including at the Annual Meeting of Colleges on 11 September 2018.

The Council's policy is to be transparent in all of our processes, therefore submissions are likely to be published. If you wish to make a submission but would like to remain anonymous, please indicate on your submission – either by ticking the box on the online submission form, or in your email response.

The Council is seeking feedback on this discussion document on the proposed strengthened recertification approach.

All of the feedback received will be analysed and considered by the Recertification Working Group, which will make recommendations to the Council. The Council will decide on the strengthened recertification model and develop revised accreditation standards for recertification programmes delivered by medical colleges (and, where necessary, the *Inpractice* programme for general registrants).

The revised standards will be consulted on, prior to implementation.

Any proposed changes to recertification standards for Australasian colleges will be made in close consultation with the Medical Board of Australia.