Accreditation Council for Continuing Medical Education
learn well

October 17, 2018

Carol Parreno
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Medical Council of New Zealand
Level 28
Plimmer Towers, 2-6 Gilmer Terrace
Wellington, 6011
New Zealand

Dear Ms. Parreno:

The Accreditation Council for Continuing Medical Education (ACCME®) appreciates the opportunity to comment on the discussion document "Toward strengthening recertification for vocationally-registered doctors in New Zealand."

We applaud the Medical Council of New Zealand (the Council) for conducting a thoughtful and deliberative review of the role of recertification in the evolving healthcare environment, and for listening and responding to the needs of multiple stakeholders. We fully support your focus on recertification that is evidence-based, relevant to practice, individualized, and evaluated to assess demonstrable change.

In addition, we believe that a key responsibility for accreditors and regulatory bodies is to cross boundaries and create connections between nations, systems, and professions. To support your goal of ensuring that recertification is a driver for change, we offer the following suggestions:

- International collaboration: As your document mentions, although there are differences in systems across him countries, there is also a commonality of goals. We support a global approach to CPD that identifies core values while respecting differences; the mutual recognition of accreditation systems affords physicians increased flexibility and a more diverse array of activities that meet their needs. It also benefits accreditation systems by enabling them to share best practices and lessons learned. We recommend that the Council consider recognizing other high-quality accreditation systems that are relevant to the professional development plans of New Zealand physicians.

- Alignment among regulatory systems: Your document describes the need to reduce burdens on physicians and offer activities that meet multiple requirements. We support this concept and recommend that the Council create collaborations, as appropriate, with other regulatory bodies. We have found this approach successful in the US; through collaborations with multiple certifying boards we have enabled physicians to meet requirements for both specialty certification and licensing by participation in CME. In our experience, these opportunities drive physician

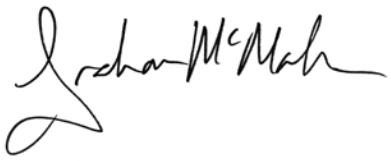
engagement; in addition, by sharing longitudinal assessment data, CME providers and certifying boards can better identify and meet physician needs. Physicians are able to find activities that count for multiple requirements by using the online search tool, CME Finder.

- Interprofessional continuing education (IPCE): There is a growing body of evidence demonstrating that participation in IPCE improves healthcare professionals' performance and patient outcomes. We recommend that the Council explore collaborations with recertification bodies in other health professions and develop strategies to drive the development of IPCE. The establishment of Joint Accreditation for Interprofessional Continuing Education in the US has greatly increased the number and quality of IPCE activities available to health professionals.

- Independence from commercial influence: We believe it is essential that physicians and the public can rely on accredited CPD to provide a protected space for physicians to learn and teach without commercial influence. We recommend that you establish a system of CPD accreditation with standards that ensure that CPD is independent of commercial interests, free from commercial bias, and based on valid content. We suggest you consider adopting the ACCME Standards for Commercial Support: Standards to Ensure Independence in CME Activities, which have become an interprofessional and international model for assuring independence from industry in the CE of health professionals. The Standards have been adopted by CE accreditors in multiple health professions in the US and the principles of independence embodied in the Standards have also been recognized as a core principle by international CCE accreditors.

We appreciate your leadership and efforts to improve practice and patient care in New Zealand and your commitment to leveraging the power of education to drive quality in our profession. We've appended several articles that explicate our suggestions; if it would be useful to you, we would be happy to share our lessons learned in the US and to discuss opportunities to further advance international collaboration.

Sincerely,



Graham McMahon, MD, MMSc
President and CEO

Enclosure:
"Evolving Alignment in International Continuing Professional Development Accreditation"
"Leading By Example: The Role of Accreditors in Promoting Interprofessional Collaborative Practice"

Evolving Alignment in International Continuing Professional Development Accreditation

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Abstract: Several of the world's accreditation systems for continuing professional development (CPD) are evolving to encourage continuous improvement in the competence and performance of health care providers and in the organizations in which they provide patient care. Clinicians learn best when they can to choose from a diverse array of activities and formats that are relevant and meet their needs. Since choice and diversity are key to meeting clinicians' needs, several CPD accreditors have been engaging in deliberate, concerted efforts to identify a core set of principles that can serve as the basis for determining substantive equivalency between CPD accreditation systems. Substantive equivalency is intended to support the mobility of learners, allowing them to access accredited learning activities that are recognized by various CPD accreditation systems in a manner that maximizes the value of those accreditation systems, while minimizing the burden of adhering to their requirements. In this article, we propose a set of core principles that all CPD accreditation systems must express as the basis for determining substantive equivalency between CPD accreditation systems. The article will illustrate how five CPD accreditation systems (two in the USA, two in Canada, and one in Qatar), differing in focus (activity-based versus provider-based), context, and culture, express these values and metrics, and concludes by identifying the value of substantive equivalency for learners, medical regulators, and CPD accreditation systems.

Keywords: accreditation, accreditor, education, regulation

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Accreditation standards for continuing professional development (CPD) of health care professionals (HCPs) are intended to facilitate the development of educational experiences that address the needs and practice gaps of HCPs, ensure independence from external influences, reduce sources of bias, ensure content is evidence informed, and facilitate continuous improvement in continuing education and the quality of health care delivery.[1–3]

Although CPD accreditation systems are perceived by some to be burdensome with an excessive emphasis on compliance with predetermined processes that depend heavily on anachronistic models of professional education, several of the world's CPD accreditation systems are evolving to encourage continuous improvement in the competence and optimal performance of HCPs and the organizations in which they provide patient care.[4–6]

Clinicians learn best when they are able to choose from a diverse array of activities and formats that are relevant to and meet their needs.[2,7–9] Those learning needs are most likely to be met when the accreditation systems recognize and encourage the growth of a broad array of educational providers and activities to maximize choice and the likelihood that individual clinicians can find activities that are ideal for them.[7–9]

Because choice and diversity are key to meeting clinicians' needs, several CPD accreditors have been engaging in deliberate, concerted efforts to identify a core set of principles which can serve as the basis for determining substantive equivalency between CPD accreditation systems. The intent of substantive equivalency is in part to support the mobility of learners in accessing accredited learning activities that are recognized by various CPD accreditation systems in a manner that maximizes the value of those accreditation systems, while minimizing the burden of adhering to their requirements.

In this article, we propose a set of core principles that all CPD accreditation systems must express as the basis for determining substantive equivalency between CPD accreditation systems. The article will illustrate how five CPD accreditation systems (two in the USA, two in Canada, and one in Qatar), differing in focus (activity-based versus provider-based), context, and culture, express these values and metrics, and concludes by identifying the value of substantive equivalency for learners, medical regulators, and CPD accreditation systems.

Disclosures: The authors declare no conflict of interest.

This article is based on an invited presentation titled "CPD Without Borders: Accreditation Around the World" delivered at the 2016 World Congress on Continuing Professional Development.

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CPD ACCREDITATION SYSTEM: A HISTORICAL PERSPECTIVE

There have been a number of attempts to define a core set of principles for CPD accreditation systems. These efforts have included work by the Rome Group[10] in 2007, followed by the Second International Forum on CPD Accreditation in 2010 (known as the Sydney Conference)[11] and the consensus statement at the Third International Forum on CPD Accreditation in 2012.[12] Several of the subsequent reports identified specific roles and responsibilities for learners, CPD provider organizations, and the CPD accreditation system.

Individual HCPs

The earliest work emphasized the importance of HCPs participating in and evaluating the extent to which learning activities were able to address their clinical practice needs and improve patient care and health; later work further defined the importance of HCPs participating in the identification of their needs, selecting learning activities linked to their professional roles and responsibilities (not just in the clinical domain), and participating in CPD as their personal and professional responsibility.

CPD Provider Organizations

Both the Rome Group and Sydney conference emphasized the importance of ensuring that commercial support did not influence the structure or content of the educational activity, the needs assessment was linked to appropriate and effective educational strategies, and there was a process and measures to evaluate the activity's educational effectiveness or the achievement of defined outcomes.

CPD Accreditation Systems

The importance of fair, consistent, and reasonable criteria was emphasized. CPD accreditation systems were required to lead with integrity, accountability, and responsiveness, promote opportunities for continuous enhancement of the standards and processes of accreditation, and engage in the spirit of collaboration. An additional emphasis was the need for the accreditor to facilitate the development of educational activities to address a range of competencies relevant to professional practice and to promote strategies to improve HCP performance and thereby improve the health of people.

TABLE 1.
Shared Principles of International Accreditation Systems

CPD Accreditation Systems Must Ensure
1. Learning activities are developed to address the needs and professional practice gaps of members of the target audience
2. The content is informed by evidence and bias is minimized
3. Learning activities are designed to efficiently maximize educational impact
4. Learning activities are planned and managed to ensure independence from external interests
5. There is a rigorous evaluation of educational outcomes including how education has impacted knowledge, competence, performance, and health outcomes
6. The accreditation standards and processes are consistently and fairly applied and continuously enhanced

CPD Accreditation and Medical Regulation

Medical regulatory authorities (MRAs) in most jurisdictions around the world recognize that engagement in lifelong learning is a requisite for sustaining quality practice and providing safe and effective patient care. Consequently, these authorities typically require engagement in CPD activities as a condition of license renewal. MRAs acknowledge the diversity of practice, and the importance of facilitating learner choice about the most appropriate and effective ways of improving their knowledge, skills, and performance. MRAs rely on standards for CPD accreditation to ensure that activities are needs based, pedagogically appropriate, assessed, balanced, and not biased by commercial interests.[13] CPD participation is increasingly being recognized as a marker of clinician quality, as reflected in the frameworks for Revalidation (United Kingdom), Maintenance of Licensure (Qatar; United States), and Physician Performance Improvement (Canada). Each of these systems relies on the presence of a robust and diverse CPD system; the success of these systems is demonstrated in the broad diversity and availability of learning activities by geography, format, approach, and intent.

CPD ACCREDITATION: DEFINING CORE PRINCIPLES

Building on this previous work, a core set of principles could serve to both guide the development (and further enhancement) of CPD accreditation systems at various stages of development and define the basis for recognition of CPD accreditation systems throughout the world. A set of core principles that could form the basis of any CPD accreditation system are proposed in Table 1.

How these principles are reflected or expressed in the standards or criteria developed by each system represented in this article is described in Table 2. The standards or criteria aligned with the core principles emphasize and honor the principle of independence, and require mechanisms to assure freedom from the influence of commercial support or other factors that could jeopardize the objectivity and balance of the educational activities. Each system should require that education be designed to address HCPs' learning needs and practice gaps; that the educational intervention be assessed to demonstrate measurable improvement in learners' knowledge, competence, practice performance, or patients' health outcomes; and that there be a process by which each CPD accreditation system will engage in continuous improvement. These shared ideals have been incorporated into the values of the International Academy for CPD Accreditation.[14]

In addition to core standards, accreditors set standards that recognize exemplary education. These standards, which are optional, serve to position CPD as a strategic resource for health care improvement initiatives, encourage best practices, and inspire continuing education providers to strive for higher achievements. For example, the Accreditation Council for Continuing Medical Education (ACCME) fosters leadership, collaboration, and system-wide change by rewarding CME providers with Accreditation with Commendation, if, among other requirements, they act as a strategic partner in quality initiatives within their institution, health system, or community through collaborative alliances. Such accredited providers must implement educational strategies to address, remove, or overcome barriers to physician change.

All accreditors engage in continuous quality improvement. Provider- and activity-based accreditation systems identify improvement priorities based on internal audit, review and

TABLE 2.

Similarities and Distinctions Among 5 CPD Accreditation Systems

CPD System/ Accreditation Principles	US—ACCME (Provider Standards)	US—AAFP (Activity Standards)	Canada—Royal College (Provider and Activity Standards)	Canada—CFPC (Activity Standards)	Qatar—QCHP (Provider and Activity Standards)
Based on needs and professional practice gaps	The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners	The provider must demonstrate how the target learners' educational needs and practice gaps were determined	A provider uses multiple methods to identify perceived and unperceived professional practice needs (knowledge, skills, performance, and health outcomes) of members of its target audience(s) across the CanMEDS framework	A needs assessment must be conducted to identify the perceived and unperceived educational needs of the target audience, including professional practice gaps, from which the educational needs of physicians are identified	A provider uses needs expressed by participants and data from assessments of knowledge, competence, performance, or quality of care provided by members of its target audiences to plan activities to meet these needs
Evidence-informed content with minimal bias	The provider actively promotes improvements in health care and not proprietary interests of a commercial interest. All recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine	Each activity must be evidence based, relevant to the scope of family medicine, and designed to ensure independence, balance, transparency, and absence of commercial bias	The provider must have a process to support the development of content that is responsive to identified needs; covers all relevant options; uses generic names (or generic and trade names) in discussing therapeutic options; and avoids exclusivity or branding	The CPD program content must be relevant to family medicine. Relevancy is determined by whether or not the content fosters improved patient care by family physicians; addresses at least one of the four principles of family medicine; and has been proven or generally accepted by the medical community	A provider has implemented a process to develop content that is based on scientifically credible evidence and provides a balanced view across all relevant therapeutic options
Effective educational processes	The provider chooses educational formats for activities or interventions that are appropriate for the setting, objectives, and desired results of the activity	The provider must select the best format and modalities to provide education to address American Board of Medical Specialties/ Accreditation Council for Graduate Medical Education core competences to achieve knowledge, competence, performance, and/or patient outcomes	The provider must demonstrate how evidence of the effectiveness of educational interventions or new innovations informs the design, development, and implementation of their activities. Each activity must have appropriately developed learning objectives; selects appropriate formats to address identified needs; and ensures at least 25% of the total education time is allocated to interactive learning	Learning objectives must be tied to needs assessment results; be learned centric and measureable. The program design must include a minimum of 25% interactivity and the content addresses the barriers to practice and/or physician change	A provider will apply interprofessional education principles (whenever applicable) in designing activities. All accredited CPD activities must ensure 25% of the CPD activity includes interaction with participants
Ensures independence from external influences	The provider develops activities/educational interventions independent of commercial interests. The provider appropriately manages commercial support. The provider maintains a separation of promotion from education. The provider identifies and resolves conflicts of interest for faculty and planners. Information about commercial support and relevant financial relationships of faculty and planners are disclosed to learners	CME activities must be planned and provided independent from external interests, in full compliance with the ACCME Standards for Commercial Support and the American Medical Association (AMA) Council on Ethical and Judicial Affairs "Gifts to Physicians from Industry"	A provider must have implemented written policies and procedures to ensure planning and decision making related to the identification of needs, learning objectives, speaker selection, content development, and evaluation of outcomes are under its exclusive control. The provider must demonstrate that there is a process to gather, manage, and disclose conflicts of interest for members of the planning committee, speakers, and moderators	A scientific planning committee must ensure decision making related to the identification of needs, development of learning objectives, selection of educational methods and speakers, delivery of content and evaluation is under its exclusive control	A provider has implemented written policies and procedures that address how relations with sponsors and/or exhibitors are managed to safeguard the planning process from commercial bias. A scientific planning committee must ensure decision making related to the identification of needs, learning objectives, format, speaker selection, content, and evaluation of outcomes is under its exclusive control

(*Continued*)

TABLE 2.
Similarities and Distinctions Among 5 CPD Accreditation Systems (Continued)

CPD System/ Accreditation Principles	US—ACCME (Provider Standards)	US—AAFP (Activity Standards)	Canada—Royal College (Provider and Activity Standards)	Canada—CFPC (Activity Standards)	Qatar—QCHP (Provider and Activity Standards)
Rigorous evaluation of educational outcomes	The provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities or educational interventions	CME providers must demonstrate that they have a mechanism in place to evaluate the activity and how the outcomes will be used to inform future planning	A provider has developed an evaluation process for individual educational activities that includes various methods to assess the degree to which the intended outcomes were achieved including opportunities for participants to identify the potential impact of the activity for their practice. All accredited assessment activities must provide data and detailed feedback to participants on their performance to identify areas requiring improvement	Participants must have an opportunity to evaluate the program using forms, discussion groups, or other techniques deemed appropriate. Evaluation must go beyond satisfaction and measure at a minimum a change in knowledge/skill/and performance	A provider has implemented a process to measure gains in knowledge, competence, attitudes, performance, or health outcomes (as appropriate) intended by an activity. All accredited assessment activities must provide detailed feedback to participants on their performance and support participants to reflect on the outcomes for their practice

The table provides a comparative representation of how common principles, shared by various accreditation systems around the world, are expressed across these systems. Although each system uses different terminology in their standards, the overall purpose of each standard is directly related to the shared principles being discussed.

assessment, external consultation with key stakeholders (using surveys, focus groups, and formal calls for comment), and participation in external peer review.[15–18] These systems work to ensure consistency and fairness by adopting a criterion-referenced decision-making system, so that expectations are clear, and all educators are evaluated using the same standards. Accreditors implement a tiered review process, where reports generated by trained peer reviewers are provided to committees for decision making. This process provides the checks and balances necessary to ensure objective and accurate decisions.[16–19] Accreditation organizations use a variety of scheduled and random audits to determine compliance and provide feedback to the provider and the system.

EXAMPLE: ADOPTION OF SHARED ACCREDITATION STANDARDS IN A NEW SYSTEM—QATAR

Before 2013, there were no accreditation standards to recognize CPD provider organizations or activities in the state of Qatar. To align and support the National Health Strategy 2016, the Qatar Council for Healthcare Practitioners (QCHP), which serves as the regulatory authority for all HCPs in the state of Qatar and the accreditation body for continuing medical education and professional development of CPD provider organizations and programs, assumed responsibility for establishing a CPD accreditation system and a credit system for practitioners.[20]

The system was designed to draw on the experience of other international accreditors to assure educational quality, and facilitate and encourage the growth of a sustainable provider community. The standards reflect the shared values articulated above, modified for the unique educational environment and culture in Qatar. The system applies to all HCPs, including nurses, physicians, dentists, pharmacists, and other allied health professions; this inclusiveness facilitates the development of interprofessional continuing education. A centralized repository of available activities is maintained.

FUTURE DIRECTIONS FOR CPD ACCREDITATION

CPD accreditation standards that facilitate choice and accommodate differences will enable educators to meet the diverse and changing needs of their learners. Accreditors can encourage and reward CPD provider organizations that shift from a teacher-centric to learner-centric focus, and that address the learning needs of clinicians across borders, cultures, generations, and professions. Accreditation standards should inspire—not constrain—CPD provider organizations from, for example, deploying new information and communication technologies, using simulation centers, games, blended learning, social media, and other applications. As new technologies emerge, as well as new research about educational effectiveness, CPD provider organizations need the freedom and flexibility to develop new learning methods.[4]

Accreditors will be most effective at supporting the evolution of CPD if they focus on educational outcomes, rather than the educational process or the time the learner spends in a particular activity. By relinquishing the fixed structural requirements for health education and instead focusing on educational outcomes or achievements, accreditors can create the right conditions for maximizing educators' flexibility and promoting innovation.[4,8,9] Some accreditors are working with specialty certifying organizations in their country to facilitate engagement in maintenance of certification, or similar activities—not only to align with a shared mission to achieve quality care but also to simplify the process for learners.

CPD accreditors can provide leadership by reflecting the community's values about what matters for CPD and what works in continuing medical education. The role of CPD accreditors is not only to establish a set core standards, expressing the shared values and principles of stakeholders, but also to design CPD accreditation standards that serve as a guidepost for the future of CPD. These aspirational standards can reward CPD provider organizations for implementing best practices in pedagogy and andragogy,

engagement, evaluation, and change management, as well as for focusing on generating meaningful educational and clinical outcomes. The standards of accreditation can advance CPD's role in the changing health environment by recognizing the achievements of educational programs that support interprofessional collaborative practice; address priorities in patient safety, public health, and population health; collaborate with health systems and communities; participate in regional, national, and international health initiatives; and contribute to measurable improvements in HCPs' practice and patient care.

CPD accreditors across the health professions, health systems, and countries need to work together to align international CPD accreditation around a set of principles that can be demonstrated by any CPD accreditation system. This approach to harmonization will accommodate learner mobility, and enable CPD educators to collaborate with colleagues around the world to respond nimbly to emerging health priorities. In addition, if more MRAs, such as licensing and certification bodies, recognize the value of continuing professional education in driving clinical practice and quality improvement and allow educational activities to count for multiple requirements, they can reduce the burden on HCPs, and motivate them to engage in lifelong learning.

Fulfilling the role of coaches and leaders, rather than enforcement authorities, CPD accreditors can support the CPD of educators, provide services that respond to educators' concerns and needs, and create an environment where they can share best practices. As enforcers, their role is restricted to establishing accreditation standards, measuring compliance, and designating the accreditation status of providers/activities. As coaches, their role expands; they engage in ongoing dialog with educators to understand and respond to their challenges, offer formative feedback, and create a framework that supports, inspires, and motivates educators to achieve their full potential. Through helping to build consensus and collaboration, the community of CPD accreditors, educators, and learners can evolve together to achieve its shared strategic vision of leveraging the power of education to improve health care.

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Leading by example: The role of accreditors in promoting interprofessional collaborative practice

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GUEST EDITORIAL

Leading by example: The role of accreditors in promoting interprofessional collaborative practice

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Introduction

The field of interprofessional education (IPE), interprofessional continuing education (IPCE), and interprofessional collaborative practice (IPCP) continues to evolve with a growing body of evidence demonstrating a positive impact on practice and patient outcomes (e.g. Reeves et al., 2016). With this evolution, there is opportunity for a broader discussion of the roles and responsibilities of different stakeholders in ensuring that health care professionals practice collaboratively, safely, and effectively. Stakeholders include but are not limited to individual health care providers; faculty; continuing education (CE) and continuing professional development (CPD) providers/organizations; professional membership associations and specialty societies; employers; accrediting and certifying organizations; and regulatory bodies. Each has a role in ensuring that health care professionals engage in CPD to maintain competence throughout their careers.

As the accreditors of the largest health care professions (medicine, nursing and pharmacy) in the United States, we have taken a significant step to leverage our role in this endeavor. Representing over five million physicians, nurses, and pharmacists who engage in CPD for their professional careers, we have created a unique program and credit system to incentivize development of and participation in IPCE. Joint Accreditation for Interprofessional Continuing Education™ offers CE providers a unified, streamlined accreditation process and set of standards. We have also held summits to convene the CE community, produced educational resources and reports, and initiated collaborations across the continuum of healthcare education and professions to further the development of IPCE. These strategies have led to a significant increase in the number of organizations developing team-based education, and an increase in the ability to measure team performance and patient outcomes. Our interprofessional collaboration can be operationalized by other stakeholders, and collectively, we can continue to positively impact health care practice and patient outcomes globally. In this editorial, we share lessons learned from our journey and identify opportunities for other stakeholders to join together.

Our journey

Our journey to interprofessional collaboration developed slowly at first, but always with a vision of using our role as accreditors to incentivize organizations to develop IPCE. We started simply, meeting several times a year to share our own accreditation criteria and identify opportunities for collaboration. We identified mutual goals of decreasing documentation burden for our CE provider community, improving alignment between our accreditation criteria requirements, ensuring we maintained foundational principles such as independence in CE, and developing a strategy to embed team-based education into organizations. Our first attempt, a streamlined application, was not successful. Although our CE providers were able to complete one application for accreditation, they were also required to write and submit three different self-study documents, addressing three different sets of accreditation criteria. We regrouped and tried again. Eventually, we developed our joint accreditation program criteria, successfully piloted the program with a small group of organizations, solicited feedback, and revised our criteria. Today, our joint accreditation program continues to flourish, and we are currently adding other health care profession accreditors to the program.

We learned many lessons throughout our interprofessional collaborative journey. We learned that we are more alike than we are different. We learned that it takes energy, trust, mutual respect, a willingness to build consensus and relinquish or adapt some of our individual approaches, and commitment to collaborate, but the end result is well worth the effort. We work together on issues that impact our shared learner community such as addressing the opioid epidemic in the United States, identifying the most effective strategies to engage learners in IPCE, and measuring the impact of team-based education on practice and patient outcomes.

Opportunities

We have learned that it is critical to continue to listen to our community of educators and learners, and work together to identify opportunities for further advancing IPCE. One of the themes we've heard continuously is that it is imperative to get

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buy-in from leadership and stakeholders across the healthcare system in order to successfully drive improvements in team delivery and patient care. Toward that end, we encourage other stakeholders to develop partnerships and use their own levers to move the interprofessional field forward. We also encourage stakeholders to publish and share their own experiences, including successes and failures. We provide several suggestions for consideration though we realize that globally, stakeholders are subject to the contexts of their own environments.

Individual health care professionals

We encourage health care professionals to identify their own learning gaps and seek out team-based education as appropriate. Health care professionals should also identify members of the teams with which they practice, and include the patient and caregiver as members of the health care team. We realize that not all learning needs are best addressed through IPCE, but we also know that health care is not delivered by individuals practicing in silos. It's important for health care professionals to be open to learning in collaboration with members of other professions and to share their own knowledge generously with others (Chappell, Regnier, & Travlos, 2017).

Faculty

We advise faculty within the health professions to seek out faculty development opportunities in team-based education. Teaching in an interprofessional environment often requires faculty to gain new skills including managing learners from different backgrounds, creating a safe learning environment, and understanding the context of the practice environment (Davis, Clevenger, Posnock, Robertson, & Ander, 2015; Silver & Leslie, 2009). Faculty engaged in and supportive of IPCE rapidly understand and appreciate the value of team-based education.

CE and CPD providers/organizations

We encourage CE/CPD providers to develop strategic education plans that include IPCE. CE/CPD providers can identify opportunities for team-based education by thoughtfully analyzing gaps to determine if they could best be addressed by team-based education, single profession education, or a combination of both, and determining how this education can support health care priorities at the institutional, community, national, or international level. IPCE programs can be a strategic resource, supporting quality-improvement and safety initiatives, and can be the stimulus for collaboration with public health departments and other stakeholders. Involving patients and caregivers in IPCE as planners, faculty and learners, can motivate powerful and lasting change.

The impact of IPCE programs will be expanded if CE/CPD providers seek out opportunities to collaborate with other organizations to develop team-based education, and explore opportunities to partner with health care organizations to evaluate the outcomes of participation in team-based education. CE/CPD providers should also share best practices, stories, and outcomes related to team-based education.

Professional membership associations and specialty societies

We encourage professional membership associations and specialty societies across the health professions to recognize and support team-based education, and to collaborate to address issues that impact the delivery of patient care. These organizations can implement strategies such as including team education as a member benefit, publishing resources for members, and collaborating with colleague organizations across the health professions to offer IPCE activities.

Employers of health care professionals

We encourage employers of health care professionals to invest in and support team-based education for their employees. Employers can choose to make team-based education a mandatory component of annual CPD. Employers also have opportunity to create an environment that is conducive to collaborative learning and practice, a critical component for success (McMahon, 2017).

Accrediting and certifying organizations

Collaboration among health care profession accreditors facilitates IPE, IPCE, and IPCP through the alignment of requirements and processes for CE providers and learners. Strategies may include team-based education as a component of accreditation criteria, as the accreditors for academic degree programs and residency programs have done in the United States and in other areas globally; collaborating as accreditors across the care continuum; and developing criteria for commendation or "stretch goals" that reward organizations for developing team-based education.

Organizations that certify individual health care professionals are encouraged to consider developing interprofessional certifications as a method to recognize team-based practice, including team-based education in maintenance of certification and licensure requirements, and recognizing IPCE credit towards requirements for recertification or revalidation. Organizations that accredit healthcare institutions, such as the Joint Commission, can require that institutions create and sustain IPCE programs as part of their institutional strategy.

Regulatory bodies

We recommend that regulatory bodies incorporate accredited team-based education into their CPD requirements. We believe that the evidence-base supporting the relationship between IPE/IPCE and improvements in practice and patient outcomes is strong enough to justify including it in regulatory requirements (Reeves et al., 2016). Regulatory bodies can also elevate the visibility and value

of IPCE by recognizing IPCE credit towards requirements for licensure as appropriate.

Next steps

As we evolve in our own interprofessional collaborative journey, we continue to support the interprofessional field in a variety of ways. We are developing tools and resources for organizations to develop team-based education, and we support other organizations in doing the same. We participate in venues to share our experiences in supporting team-based education such as the Global Forum on Value-Based Continuing Education at the National Academies of the Sciences, the National Center for Interprofessional Practice and Education, the Alliance for Continuing Education in the Health Professions, and the Conjoint Committee on Continuing Education (National Academies of Sciences, Engineering and Medicine, 2017). We have convened leadership summits for our jointly accredited organizations to share their stories, best practices, and outcomes. We have also published two publically available reports that highlight the outcomes from those summits (Joint Accreditation for Interprofessional Continuing Education, 2016; 2017).

Concluding comments

Most of the emphasis in IPE has been on the undergraduate or graduate levels, accounting for about eight years in the life of the health care professional. During the decades they spend in practice, health care professionals rely on CPD to improve their practice and patient care. To effectively integrate IPCP throughout healthcare systems across the world, we need to make IPCE an integral part of CPD for all health professions. Each healthcare stakeholder has an important role to play in this evolution. Through working and learning together, we will generate new models for team-based education and care delivery. By applying the tenets of IPCP beyond individual healthcare teams to collaborations among systems, regulatory bodies, accreditors, and institutions, we can create sustainable frameworks for transforming all health care into collaborative care.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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Submission to the Medical Council of New Zealand: October 2018

STRENGTHENING RECERTIFICATION FOR VOCATIONALLY-REGISTERED DOCTORS IN NEW ZEALAND

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback on Medical Council of New Zealand's *Strengthening Recertification for Vocationally-Registered Doctors in New Zealand*.

ACEM is the not-for-profit organisation in Australia and New Zealand responsible for the training and education of emergency physicians and advancement of professional standards in emergency medicine. As the peak professional organisation for emergency medicine across Australasia, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients.

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

In general these components seem reasonable, however some elements will require very clear explanation regarding what is expected of Colleges in order to ensure certainty of all stakeholders. The concept of ensuring appropriate CPD in the scope of practice is welcomed; offering RPR could be incorporated relatively easily in general scope emergency practice, but may be more difficult in other areas e.g. pre-hospital retrieval medicine.

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

Activities such as MSF, audit, RPR (or other peer review) are likely to be included in the Medical Board of Australia's (MBA) new CPD requirements, which will make it easier for Recertification providers (e.g. colleges) to meet the requirements of both regulation authorities.

Consideration to how often the bigger exercises (e.g. MSF) would occur is important - annually would be too frequent for the vast majority of doctors to see much improvement, let alone justify the significant investment in time and logistics. The small number of doctors who have more than mild deficiencies in their practice (for example communication skills or a clinical deficiency), may benefit from a more frequent review. As such, this small number of "at risk" practitioners who need some focused attention, need to be identified. Again, clarification of the expectations on providers (e.g. the Colleges) is important.

Notwithstanding the above, ensuring CPD providers are given the latitude to consider how best to implement the key components for their participants is also important in order to enable appropriate relevance for specific groups. It is also important to undertake an appropriate communication program in the lead up to the changes to ensure the information is appropriately promulgated and understood by all involved.

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

RPR may be seen as problematic for some groups where peer review is not presently embedded. Even in emergency medicine (where peer review occurs daily) a formal RPR may be met with some reservations regarding issues such as practicality and cost. It is understood that RPR is well established in New Zealand some in vocational scopes; however, similar issues with measuring outcomes that the MBA are grappling with may also apply to NZ doctors practicing in vocational scopes where RPR is not well established, and where the doctors concerned practice predominantly in team-based arrangements (e.g. emergency medicine).

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?

Again, clear expectations regarding the expectations of the MCNZ on providers is considered essential to the process. Also, given the trans-Tasman arrangements of many providers, consideration to the changes underway in Australia with the MBA Professional Performance Framework (PPF) would be beneficial. Colleges are anticipating major changes to how CPD programs are implemented and, as much as possible, being able to have one overarching program would be beneficial to providers, regulatory bodies and participants.

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

MCNZ requirements already include an audit of medical practice and peer review, activities that appear to be evidence-based and which are thought appropriate to be mandated. Including the PDP is also considered appropriate

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?

Emergency Medicine by and large is a team discipline which lends itself well to work-place based peer review (by colleagues at the same or difference facilities). In many settings this already takes place to some extent e.g. M&M, case presentations, handovers, team-leading other emergency physicians in critical cases and debriefing afterwards. Trying to incorporate as many existing activities as possible is helpful both for minimising cost but also increasing acceptability for doctors.

Formal handovers within entire emergency department are conducted at least twice (if not three times) per day. In most hospital settings this is with a number of doctors but even in single practitioner small rural hospitals, this involves one-to-one review of patients. Those practitioners who work solo in rural areas may be slightly more ‘at risk’. At risk practitioners need to be identified and given more support compared to the majority of others.

Clearly, given the nature of emergency medicine practice, ACEM would need to consider how RPR is incorporated to ensure that relevant information is obtained in regard to the practice of the individual practitioner as distinct from the team in which they practice.

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

As outlined above, as far as possible, it is important to have synergistic programs in Australia and New Zealand. Both MCNZ and MBA appear to be considering very similar changes and there is clear need to ensure there is ongoing dialogue between stakeholders to ensure a practical outcome in both countries.

Thank you for the opportunity to provide feedback to the Medical Council of New Zealand. Should you require clarification or further information, please do not hesitate to contact the ACEM Continuing Professional Development Manager, Ms Andrea Johnston on +61 3 9320 0444 or via email at andrea.johnston@acem.org.au.

Yours sincerely,

Dr Simon Judkins
President

[redacted]

COMPLETE

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Started: Thursday, October 04, 2018 1:13:44 PM
Last Modified: Thursday, October 04, 2018 1:25:32 PM
Time Spent: 00:11:48

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Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think that the move towards a more evidence-based formative approach to recertification is excellent

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think that compulsory Regular Practice Review as a good idea although there are significant logistic issues. I think that a regular practice review should not be required more than once every three years. I think that multisource feedback and 360° reviews are superfluous if a thorough regular practice review is undertaken.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

There are logistic challenges to the implementation of Regular Practice Review. The biggest challenge in terms of data collection and availability for practitioners who do not work in a hospital and not in procedural medicine are significant, and need to be taken into account when mandating recertification based on data.

Q4 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?

There are two major issues for the Australasian College of Sport and Exercise Physicians which is a trans-Tasman College. The first is the reconciliation of the currently changing Australian requirements for recertification with the proposed New Zealand changing requirements. The more that the two countries can align in terms of their requirements for recertification the easier this process will be. The other concern is as noted above in that sport and exercise medicine is largely in private practice and is largely not procedural and data collection is challenging.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Regular Practice Review I think should be mandatory every few years

Q6 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?

The Australasian College of Sport and Exercise Physicians has embraced the concept of formal peer review groups and these work extremely well. We have recently begun to encourage Regular Practice Review and those physicians who have undertaken this have been very positive about the value of the experience. We also encourage regular professional supervision of our fellows as an option for peer review.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The most important practical aspect of this approach is the reconciliation between Australian requirements and New Zealand requirements, and the understanding that data collection in private non-procedural medicine presents a significant challenge.

Page 2: Submission information

Q8 Your information:

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Q9 Your position/title:

Chair of CPD

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: Rachel Wiseman <Rachel.Wiseman@cdhb.health.nz>
Sent: Friday, 19 October 2018 8:08 p.m.
To: Strategic Consultation
Subject: Re: Strengthening recertification for vocationally registered doctors in New Zealand

Categories: Blue Category

Kia ora,

I am writing on behalf of the Australia and New Zealand Society of Palliative Medicine Aotearoa committee. We represent medical practitioners of palliative care in New Zealand, including vocationally registered specialists, trainees, Medical Officers and General Practitioners practising in palliative medicine services.

We find the increased emphasis on peer review and regular practice review heartening. Due to the complex nature of care at the end of life, palliative medicine practitioners are generally part of large, multidisciplinary teams and there is usually frequent opportunity for discussion of individual cases. Peer review is regarded as an essential component of palliative care practice.

However, vocationally registered palliative medicine specialists are few in number and geographically widespread, there are a number of centres with a single vocationally registered specialist (In the South Island for example – Nelson, Blenheim, Timaru and Invercargill). This will lead to significant challenges with regard to formal peer review or regular practice review for these solo practitioners. As a society, we would hope that any peer review or regular practice review process will ensure that:
Peers could be considered to be vocationally registered specialist from an allied specialty (such as oncology or geriatrics), particularly in locations where there is a single vocationally registered palliative medicine practitioner
A peer review process could be supported across DHB boundaries. For example, a palliative medicine specialist could support and provide peer review to a solo specialist in a neighbouring DHB.

Many thanks for the opportunity to feedback on this discussion document
Regards
Rachel Wiseman

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October 24, 2018

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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.

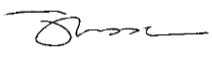
ANZCA now has a mature CPD programme that has a very high compliance rate (>99.6% across Australia and New Zealand) and a high acceptance rate among its fellows (>80% rate the programme favourably for relevance and usability). The ANZCA and FPM CPD committee is about to commence a five-year review of 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



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13 November 2018

Carol Parreno
Medical Council of New Zealand
By email sconsultation@mcnz.org.nz

Dear Carol

STRENGTHENING RECERTIFICATION FOR VOCATIONALLY-REGISTERED DOCTORS IN NEW ZEALAND

1 Thank you for the invitation to provide feedback on the above discussion document. We are writing as lawyers who regularly act for doctors assisted by a professional indemnifier.

2 From the discussion document, we understand Council has identified a need for there to be a greater focus on the effectiveness of recertification activities. The discussion document's section on 'a proposed approach' then suggests that recertification programmes use an evidence-based, rather than a time-based approach. The discussion document suggests by way of example (on pages 12 and 13) that recertification programmes could include a component of 'essentials knowledge' covering, amongst other things, *Good Medical Practice*, other statements adopted by Council and relevant legislation.

3 This submission is limited in scope. We write in support of recertification programmes including a compulsory component of 'essentials knowledge'. In our experience there are, for example, some Council statements that are not well-publicised or well-known and understood by the medical profession. It would be in the interests of individuals and the profession as a whole for CME activity to incorporate the medico-legal aspects of being a medical practitioner.

Yours sincerely

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[redacted]

From: Daniel Calder [redacted]
Sent: Thursday, 25 October 2018 3:51 p.m.
To: Strategic Consultation
Subject: Follow up on MCNZ - Strengthening Recertification Discussion Document feedback

Dear Carol

Many thanks for the opportunity to provide feedback regarding the suggested recertification for medical practitioners. I have previously submitted a personal response via Survey Monkey. Please find below feedback on behalf of East Health Trust PHO:

- Similar recertification currently exists in the UK and it is not entirely clear to what extent this is benefitting patients or clinicians
- There needs to be clear demonstration of how recertification is intended to lead to improved outcomes when compared with current state
- Admin burden for clinicians is already significant and recertification will add to this
- There is a risk of senior GP's opting to taking early retirement or looking for alternative employment rather than participate in extensive recertification programmes.
- NZ could do with more doctors, in particular more GP's. This type of scheme will add a further barrier to recruitment at a time when other countries are looking at ways of reducing these barriers. It is worth noting that the UK is actively pursuing avenues to increase recruitment of Australian doctors as well as encouraging British ex-pats to return. It could be anticipated that they turn their attention to NZ doctors next.
- Doctors currently engage with a range of continued professional development activities, in particular peer review and CME. Need to be mindful that recertification does not distract from this.

Kind regards
Daniel

Daniel Calder
Clinical Director

East Health Trust PHO
[redacted]

From: SConsultation@mcnz.org.nz [mailto:SConsultation@mcnz.org.nz]
Sent: Thursday, 18 October 2018 3:53 PM
To: SConsultation@mcnz.org.nz
Subject: Follow up on MCNZ - Strengthening Recertification Discussion Document feedback

[redacted]

From: Fleur-Ange Lefebvre
Sent: Friday, 19 October 2018 4:05 a.m.
To: Strategic Consultation
Cc: Louise Auger
Subject: FW: MCNZ - Strengthening Recertification Discussion Document for feedback
Attachments: Survey Questions on strengthening recertification Sept 2018 word version.docx

Categories: Blue Category

Good morning, Carol and Raylene.

Thank you for inviting us to provide feedback on the discussion document. As promised, I circulated the information to the medical regulatory authorities across Canada. I also had an opportunity to meet with Joan in Dubai.

(Please note that I would not be completely surprised if some of the provincial regulatory authorities also responded on their own – c'est la vie!)

We agree, overall, with the following:

a) The MCNZ approach continues to be a strong process. While working on the FMRAC Physician Practice Improvement System (approved in 2016), the FMRAC Working Group had a chance to review and appreciate the current program. We believe the new proposal is commendable and a step in the right direction.

b) We have two suggestions:

   a. Remove "profession-led" as a principle and embed that term in the vision, e.g.:

> **Vision**
>
> Profession-led 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 continued improvement in performance.
> ***OR***
> Recertification is a profession-led process that 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 continued improvement in performance.

   b. Nowhere in the document is mention made of team-based care or team-based education. Given that that is now the every day reality of medical practice for these physicians, this should perhaps be embedded as a principle or in another way to ensure it is an ongoing consideration in recertification in New Zealand.

I trust these comments will be taken as helpful suggestions.

Sincerely,

Fleur-Ange

Fleur-Ange Lefebvre
Executive Director & CEO / *Directrice générale et chef de la direction*
Federation of Medical Regulatory Authorities of Canada / *Fédération des ordres des médecins du Canada*

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25 October 2018

Carol Parreno
Strategic Project Manager
Medical Council of New Zealand

Email: sconsultation@mcnz.org.nz

Kia ora Carol

Re: Feedback on the proposed strengthened recertification approach

Thank you for the opportunity to provide feedback on the Medical Council of New Zealand's (MCNZ) discussion document *"Towards strengthening recertification for vocationally-registered doctors in New Zealand".* We offer the following comments for your consideration and have addressed each of the questions in turn.

Question 1: What are your thoughts about the key components of the proposed strengthened recertification approach?

- *In terms of feedback on the key components of the proposed strengthened recertification approach we agree with the overarching goal that underpins the proposal; namely to provide assurance of the competence of doctors, to maintain high standards of practice, and to move to a more flexible certification programme that recognises the differences in workplace settings and is focused on improving an individual's practice.*

- *We agree with the principles stated in the document, with recertification activities based in the doctor's actual workplace. This will take into account the many varied roles that doctors in clinical and non-clinical roles undertake. Transition to the new approach and cost impacts however need to be considered (see later).*

Question 2: What suggestions do you have about how these key components could be implemented in recertification programmes?

- ***A profession-led approach appropriate to scope of practice*** *- we feel that this approach allows Colleges to direct activity appropriate to their membership needs and scope of practice. Overall, we agree it would be useful for e.g. the Royal Australasian College of Medical Administrators (RACMA) to direct the continued CPD requirements for their members to reflect the many different roles that medical administrators undertake. We feel that this should be a co-design process and would allow flexibility of*

CPD activity for a RACMA member working as a CEO of an organisation versus CPD for a member working in a pharmaceutical agency.

- *Colleges should not be the sole providers of CPD activity but need to recognise CPD activity provided by internationally recognised organisations such as the Institute of Healthcare Improvement (IHI) or Kings Fund (UK). These organisations provide courses and conferences that would be pertinent to those working in the patient safety or quality improvement fields and could contribute to an individuals CPD activity. A common standard framework to assess and recognise external non-College provided for courses and conferences should be in place for all Colleges.*

- ***Increased emphasis on evidence value of activities and peer review*** *–*
  - When looking at data and evidence to assess outcomes of clinical or non-clinical practice the attribution of an outcome to an individual's practice versus the team contribution can be problematic. Much of a doctor's practice in todays medicine occurs within the team setting, and as such outcomes are most often attributable to and reflect a team effort.
  - Working as part of a team means that much of a doctors practice is already subject to peer review both in clinical and non-clinical roles. As an example, Board or national position papers written in central agencies are subject to a strict audit path and peer review often by more than one colleague. Additionally, these papers are then also discussed more widely with the healthcare sector. Would MCNZ consider recognising some of this activity as peer review CPD activity?
  - Although MCNZ has defined audit as more than a clinical activity, audit of practice in non-clinical settings or unique roles can pose a challenge. With clinical interventions outcomes are more defined, whereas for medical practitioners working in central agencies attributable clinical outcomes are less clear. In some central roles might performance review and achievement of key performance indicators by employers be considered for outcome assessment? College input and examples would also be helpful in helping members direct this activity.
  - Benchmarking again maybe a challenge for doctors working in more 'unique' roles. We also feel that MCNZ should consider a longer time span to be permissible for audit and that collection of data over 2-3 years and submission at that point would be useful. This would also allow for the work in central agencies, which often spans financial years to be aligned with CPD activity that spans calendar years.

- ***Education and development relevant to workplace and career planning*** *- we agree that this will help in recognising the many diverse settings that occur especially in non-DHB settings. Recertification should reflect the individuals work and career plans in the context of their employment role. This will allow for those working in central agencies to allow for education focused on systems thinking, clinical governance, and clinical leadership which would better reflect the varied roles undertaken to be recognised.*

- ***Use of a professional development plan (PDP) to guide learning*** *- we agree with this approach and that a PDP be recognised for CPD activity. MCNZ and Colleges will also need to recognise that PDPs in central agencies may also need to reflect organisational strategic priorities in addition to personal development needs so that two separate PDPs do not need to be undertaken. PDP should reflect previous CPD activity and areas for improvement and aspirations.*

- ***Other comment***
  Although conference attendance may not have been identified as contributing as effectively to CPD there are aspects of College annual scientific meetings and international conferences that MCNZ should consider as pertinent. This relates to the networking and discussion opportunities that provides informal peer review but also establishes a network of resources to tap into for support/peer review in the future. The value of conference networking should not be completely dismissed.

Question 3: Do you foresee any challenges with implementing the proposed approach? What are these and why?

- ***Offering regular practice review (RPR)*** *- although we agree with this approach we see that there maybe some challenges. For some unique medical roles international peer review may be needed for RPR. If this is the case then this needs to be done in a manner that is not costly for organisations and should not be a burden or expense for the doctors themselves. RPR may be covered by Association of Salaried Medical Specialists (ASMS) MECA agreements within DHB settings but may not necessarily be covered by independent employment agreements. This could then result in a financial burden either for the practitioner or the organisation. This cost burden needs to be recognised with perhaps a reduced frequency of RPR. The time and costs for those providing RPR for doctors also needs considering. Again this activity for those in independent employment agreements may need to be undertaken either as annual leave or time off without pay so should not be onerous.*

- *Flexibility may be needed and an evaluation of the impact of RPR should be undertaken early following its introduction with monitoring to ensure there are no unintended consequences of the process.*

- ***Specified CPD hours and type*** *– we agree that there should be some directed CPD activity that is common to all practitioners, and activities that are evidenced as having the best outcomes in terms of improvement should be weighted more heavily. See later for essential knowledge that should be common to all doctors and be part of CPD requirements set by MCNZ.*

Please note previous comments regarding data attribution.

Question 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?

- *As previously stated Colleges should not be the sole providers of CPD activity but need to recognise CPD activity provided by internationally recognised organisations such as the Institute of Healthcare Improvement (IHI) or Kings Fund (UK). These organisations provide courses and conferences that would be pertinent to those working in the patient safety or quality improvement fields and could contribute to their CPD activity. A common framework to assess and recognise external non-College provided courses/conferences should be in place for all Colleges.*

Question 5: Do you think there are any recertification activities that should be mandatory for all doctors?

- *Some areas of practice such as communication and cultural safety are key components for everybody working in health and therefore should be common components across all the medical Colleges. This development should be led by the Council of Medical Colleges. Costs of any new approach, especially for smaller Colleges, need to be kept to a minimum through sharing of resources, development of common e-modules. Consumer engagement, shared decision making and clinical governance should also be core components for all medical practitioners. Some Colleges could help in module development or take a lead e.g. RACMA on topics such as clinical governance and clinical leadership. Equally some central agencies such as the NZ Health Quality & Safety Commission could lead or help with quality improvement or patient safety modules.*

Question 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?

- *When looking at data and evidence to assess outcomes of clinical or non-clinical practice the attribution of an outcome to an individual's practice versus the team contribution can be problematic. Much of a doctor's practice in todays medicine occurs within the team setting, and as such outcomes are most often attributable to and reflect a team effort.*

- *Working as part of a team means that much of a doctors practice is already subject to peer review both in clinical and non-clinical roles. As an example Board or national position papers written in central agencies are subject to a strict audit path and peer review often by more than one colleague. Additionally these papers are then also discussed more widely with the healthcare sector. Would MCNZ consider recognising some of this activity as peer review CPD activity?*

- *As previously stated the challenge of RPR is the unique settings for some medical practitioners in New Zealand, which might require an individual's practice to be peer-reviewed by international colleagues. The cost burden of RPR needs to be considered as will this fall on employees or employers. If international peer review is required this would bring additional costs. Perhaps a reduced frequency of RPR could be considered. If the RPR focuses only on areas of practice that could be covered by another New Zealand based doctor, this may not cover the unique competencies required in these roles, and would not strengthen the recertification process focused on an individuals workplace setting.*

Question 7: Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

- *For those in central agencies whose employees are public servants and who may sit outside of the collective bargaining such as ASMS MECA agreements, it would be useful to ensure that government agencies, academic institutions and other organisations also support and invest in the recertification and CPD of their employed doctors? Currently there is a variable approach to the level of support in non-DHB settings with varied time and expenses allowed for both CPD and College activities.*

- *Although we agree with MCNZ's approach we are also mindful that this should not come at an increased cost to College members through membership fees or to their employers. There must be provision for online education using webinars and e-modules and perhaps a reduced frequency of RPR.*

- *We would suggest a reasonable transition period for introducing the new programme during which there is flexibility in terms of what can contribute to CPD, how data could be sourced or presented and for RPR approaches to be considered, developed and implemented by individual Colleges.*

- *We would also suggest that there is an evolution of the evidence as stated in the document. As the environment and expectations continue to evolve it would be useful for MCNZ to build in an evaluation of the new approach. Perhaps a survey of both Colleges and practitioners could be undertaken in 2-5 years.*

- *Flexibility may be needed for RPR and an evaluation of the impact of RPR should be undertaken early following its introduction with ongoing monitoring to ensure there are no unintended consequences of the process.*

- *We commend the approach and the aim of MCNZ to move the mindset from a CPD compliance exercise to a more continuous quality improvement activity. We would encourage MCNZ to position the proposal as one with a focus on improvement that is continous but reported by a practitioner on an annual basis.*

Once again, many thanks for the opportunity to comment on the discussion document. If you have any questions or require any clarification of these points, please do not hesitate to contact: iwona.stolarek@hqsc.govt.nz.

Yours sincerely

Janice Wilson (Dr)
Chief Executive

Iwona Stolarek (Dr)
Medical Director

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, October 01, 2018 9:36:54 AM
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Time Spent: 00:08:40

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Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The NZ branch of the Australian College of Health Informatics broadly supports the proposed changes for the recertification of practitioners including those who also have Clinical Health Informatics as part of their current role. The proposed system is broadly applicable for most practical situations. Deviations should be explained to the employer and the college via the active review of the PDP. Ideally, the balance should be self-evident within the practitioner's practice. The key, for an emerging specialty like clinical health informatics, is the linkage of recertification to current role, not the college of origin.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The NZ branch of the Australian College of Health Informatics would argue that recertification should be based on the individual's PDP and their current role within the health system. Anything that avoids etherial goals like resolving world hunger is to be encouraged. The PDP needs to contain SMART goals, and the practitioner needs to be accountable for delivering against those goals. The Australian College of Health Informatics needs to support practitioners and practice, through a consultation process, to provide guidance on what is reasonable and appropriate for a PDP in Clinical Health Informatics. This still allows practitioners choice but limits the burden of justification to regulators of only the exceptions from the college's guidance. The intention is that the justification for such exceptions from the College guidelines is self-evident from the practitioner's role description.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The NZ branch of the Australian College of Health Informatics position is that recertification should be focused on the practitioner's current role, not their historical college or origin. This view also encompasses the college's reality that practitioners of Clinical Health Informatics need not be originally only medical practitioners and the provision of CME by the College needs to equally applicable to colleagues who were originally Nurses or Allied Health Practitioners. The real challenge is the appropriate audit in clinical health informatics, detracts from audit activities in the practitioner's vocational scope as such may not be recognized as appropriate CME. As an example, if I am a surgeon who performs gastroscopies for 20% of my clinical practice then the 20% of my CME in this area, counts towards my overall CME total, with failure to do so being unacceptable. If I spend 20% of my time on clinical health informatics, the 20% of my CME spent equally appropriately does not count towards my overall CME total, so I am seen as deficient in my CME activities. Equally, if I do no CME towards my 20% role as a clinical health informaticist then I will be recertified as a 100% compliant practitioner. Process capture by the larger, well connected and influential colleges is a significant challenge for the smaller colleges and any societal aspirations for a diversified, in terms of skill mix, workforce.

Q4 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?

The NZ branch of the Australian College of Health Informatics fully accepts that it needs to work with industry partners like HINZ to develop an appropriate CME framework and provide specific activities, to provide such a framework. Any such framework needs to encompass the full spectrum of practitioners from the part-time practitioner for whom Health informatics is an adjunct to the full-time specialist practitioner in Clinical Health Informatics. RPR for a small college will provide some logistic and fiscal challenges, depending on the funding formula. The former college will overcome, the later is ethically more challenging, as medical practitioners are only a portion of the College fellows, who could consume a disproportionate share of finite resources. A suggestion is the central governance of funding on a per medical practitioner to ensure all practitioners get similar access to similar levels of recertification activity. Otherwise the larger, and richer, colleges will distort the marketplace for recertification delivery if only for their size.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, while the process should be mandatory, the content needs to be role based within the context of the individual career to date and future aspirations. All current mandated processes are open to subversion, the CME group which is more a gossip session over wine and cheese, by the cynical and disengaged. A mandatory recertification process should involve colleagues in meaningful peer review and support within the basis of role should involve employers so it makes sense in the workplace, and should involve pertinent CME.

Q6 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?

From the perspective of the Australian College of Health Informatics, appropriate recertification processes can be delivered. By definition, our small workforce is highly computer literate, with easy access to online training and recertification materials. The annual conference is lively and growing in size. The college accepts it needs to do more, but can easily do so within the framework. RPR for a small college will provide some logistic and fiscal challenges, depending on the funding formula. The former college will overcome, the later is ethically more challenging, as medical practitioners are only a portion of the College fellows, who could consume a disproportionate share of finite resources.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The key will be around meaningful engagement with the practitioners, the employers, and the colleges as providers (and in theory at least non-college providers). Change can be captured by the powerful or incumbent providers, for this proposal to succeed it needs to empower the individual to engage with providers, which will usually be their college, but this should be decided by the individual.

Page 2: Submission information

Q8 Your information:

Name	**Dr Greig Russell**
Company	**MidCentral DHB / Australian College of Health Informatics**
Email Address	**greig.russell@midcentraldhb.govt.nz**

Q9 Your position/title:

Principal Medical Information Officer (MidCentral DHB)

Q10 This submission is on behalf of:	**Group**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

NEW ZEALAND COLLEGE OF
PUBLIC HEALTH MEDICINE

18 October 2018

Submission to the Medical Council of New Zealand: Strengthening recertification for vocationally-registered doctors in New Zealand

The New Zealand College of Public Health Medicine (NZCPHM, the College) thanks the Medical Council of New Zealand (the Council) for the opportunity to make a submission on the document 'Strengthening Recertification for Vocationally-Registered Doctors in New Zealand'.

The NZCPHM is the professional body representing the medical specialty of public health medicine in New Zealand. We have 236 members, all of whom are medical doctors, including 183 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

Background

The NZCPHM recognises the importance of systems that provide assurance to the regulator and the public that medical practitioners are maintaining their competence and continually seeking to improve their practice.

We agree with the Council that any changes to current recertification requirements should not create an additional administrative burden, duplication of process or added layers of bureaucracy.

We support the Council's Vision and Principles for Recertification, published in 2016. We appreciate and support the Council's 'high trust' approach to recertification.

We further support any developments which move away from a 'tick-boxing' approach to recertification and would encourage a move in the direction of activities which have clear and obvious relevance to medical practitioners ('face validity'). Activities which are perceived to be relevant are more likely to ensure positive outcomes and behavioural change.

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Consultation questions

Our responses to the consultation questions are provided below.

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

1.1 A profession-led approach, appropriate to scope of practice

The NZCPHM agrees with the Council that medical colleges are the most appropriate bodies to determine the types of activities that are relevant to, and should be undertaken by, doctors in that scope of practice.

We note the suggestion that doctors should be able to map their continuing professional development (CPD) activities to their scope of practice, usually by reference to a college curriculum. A college curriculum is a useful tool for enabling doctors to select activities that are appropriate to their scope of practice. For example, our Fellows are required to consult our competency list when drawing up their professional development plan (PDP) for the year and submit a marked-up copy of this list of competencies if audited. However, we do not believe that it should be a requirement that all activities should be 'mapped' against a curriculum: educational activities typically do not neatly fall into one curriculum outcome area, and 'mapping' would be burdensome and would not necessarily provide information that is relevant to the individual doctor's practice and previous experience. We note that there is a wide variation in the roles undertaken by public health medicine specialists and that these requirements must be considered in determination of individual professional development needs.

1.2 Increased emphasis on evidence, value of activities and peer review

The NZCPHM agrees that recertification programmes should, where possible, be based on activities that have been demonstrated to contribute to learning and that doctors should, where possible, use performance and outcome data and external peer review to identify their professional development needs.

We note that that what constitutes relevant performance and outcome data at the individual level will vary between scopes, and that for public health medicine, it would not be appropriate to use data that relates to individual patients. Peer review is already built into the processes of many of public health medicine outputs currently recognised for recertification purposes, such as academic publication (notably those published in peer reviewed journals), policy development, and media engagement. In other cases, performance and outcome data may not be easy to obtain. We are currently piloting a multisource feedback tool to determine its value as a data source for public health medicine.

1.3 Education and development relevant to workplace and career planning

The NZCPHM supports the principle that education and development should be relevant to the individual doctor's work context and career plan. Recertification programmes should therefore be sufficiently flexible to allow doctors to plan and select activities that will best meet their needs.

1.4 Use of a professional development plan (PDP) to guide learning

The NZCPHM supports the use of an individualised PDP for each doctor as a central part of recertification. We also support the requirement that doctors will be expected to review their own PDP each year, with input from an external reviewer. This is already a requirement in our recertification programme (TOPS) and has been available since 2004.

1.5 Offering regular practice review

Although there may be value in direct observation of consultation or procedural skills, the NZCPHM is not convinced of the value of a practice review visit for non-clinical practice. Physical visits are costly to undertake, and, in the case of public health medicine, may not result in meaningful observations. We note again the wide variation in the roles (often largely desk-based) undertaken by public health medicine specialists. We believe that MSF may be a better means of review for public health medicine. This approach will be tested when we pilot our new MSF tool in 2019.

If the purpose of the visit is to provide an opportunity to allow the doctor to reflect on their practice with external guidance, there may be other means to achieve this for our scope. For example, our current TOPS requirements include a discussion of the annual professional development plan with a colleague. This process could potentially be strengthened, for example, by periodically including the results of a multisource feedback tool or discussion about longer terms career plans. This activity could be done without the need for costly visits. In addition, we are in the process of establishing a TOPS Advisory Committee whose role will be to provide advice and support to TOPS participants who are having difficulty meeting their TOPS requirements or who wish to discuss issues identified in the MSF process. Other outputs which have peer review and audit built into their processes also provide reassurance and feedback on performance.

In summary, the NZCPHM does not support the requirement for all programmes to offer an RPR. If this is to be required, there would need to be considerable flexibility regarding the form of the review, and how it is conducted.

1.6 Specified CPD hours and type

We understand the document to be saying that the Council will not specify a minimum number of hours per category and agree that it is more appropriate that the colleges set any such minima for their own scopes. We further agree that it is appropriate that the requirements set by colleges for specific types of activities be determined according to the evidence for effectiveness of those activities, where this exists.

Given the general thrust of the evidence referred to in the consultation document, we hope that sufficient flexibility will be given to allow colleges to remove requirements for passive education, in favour of an approach which more strongly emphases the completion of activities outlined in an individual PDP, informed by college curricula and by the doctor's individual context and career plans.

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

The NZCPHM is not able to comment on how the specific components detailed in the document could be implemented in other scopes. However, we agree with the suggestion implicit in the 'roles and responsibilities' model provided that overall implementation and monitoring should be via the accreditation and reaccreditation process for vocational scopes of practice. In line with those processes, the approach adopted should be formative rather than summative, allowing for the development of programmes over time.

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

The two areas that will pose the greatest challenge in terms of implementation are the use of performance and outcome data to inform a doctor's professional development, and implementation of an RPR.

Regarding data, the NZCPHM is currently rolling out a pilot of a multisource feedback process which we consider will provide useful evidence to be used by doctors as an input into their annual professional development plans. How effective this will be at identifying areas for development is yet to be determined. The implications of rolling out on a larger scale are also yet to be determined – there is a concern that regular and compulsory administration of the tool may lead to survey fatigue, as the same people will be asked to complete surveys frequently.

In regard to the RPR, see our comments under 7.1.5 above. Any requirement that involves periodic 'visits' to doctors around the country will be costly to implement and the benefits would need to be considerable to justify this cost.

4. Are there any specific implementation concerns for recertification programme providers? Do you have any suggestions about how these issues could be resolved?

Key implementation issues will include:

- finding appropriate tools for providing performance data, if any are required in addition to the new MSF tool which will be introduced in 2019 on a pilot basis
- having sufficient time to pilot and adopt new tools and requirements
- having the time and resources needed to plan for and implement technology system changes
- finding resources needed to implement RPR visits, if this is to be required. If a physical visit is required, the cost of arranging these may be prohibitive.

The NZCPHM works on a very small budget and membership fees are already high. We would not be in a position to implement any solution that required significant funding or membership fee increases.

Any changes to be made would need to fit within our triennium programme timeline: our next triennium begins 1 January 2019, and changes to be made in that triennium have already been approved and are in the system-build phase. The next opportunity to make changes within this cycle is for the triennium beginning 1 January 2022.

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

The NZCPHM believes that it is appropriate that medical colleges determine the requirements for the programme under their purview. However, we would support a Council requirement for certain activity categories to be included in all programmes, and would suggest that these be PDP, peer review, cultural competence development, activities aimed at improving health equity, and activities aimed at improving population health.

If the Council wishes to set mandatory requirements for tests of specific learning (such as knowledge of Council regulations and policies), we believe that this should be done outside of college processes.

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?

(See 1.5) The NZCPHM is not convinced of the value of a regular practice review visit for non-clinical practice. Considerable flexibility in interpretation of the RPR requirement would be necessary to make this approach relevant to public health medicine.

It is also not clear how much of this process is already taking place as part of employers' annual performance review processes: duplication should be avoided.

7. Other comments or suggestions?

The NZCPHM believes that there are two further core components that could be added to the model proposed.

- Supporting a high level of cultural competence. This requirement would align with the Council's focus on this area and the high level of consensus that this is a critical area to be specified in recertification programmes.
- Supporting a high performing and equitable health system. Activities which contribute to equity, access, system efficiency (and good use of resources), evidence-informed practice, and to improvements in population health should be explicitly valued. A population health perspective is particularly important given the large health implications of threats such as climate change (including the need for emergency response planning) and anti-microbial resistance. These complex threats require doctors to work in more coordinated ways and could be supported by identifying them in recertification programmes.

With regard to the 'roles and responsibilities' model in section 5 of the document, we note that the model is silent on the connection between a recertification programme and the granting of a practicing certificate (PC), which is a Council responsibility linked to satisfactory completion of the

requirements of a recertification programme. Currently Colleges are required to report non-compliance with CPD requirements to the Council and the Council audits the CPD participation of a proportion of all doctors. It would be useful if these roles were included in the model, and the Council indicates whether it anticipates that there will be any changes to this arrangement, or in the information that must be provided by the Colleges to the Council?

We note also that the column under MCNZ responsibilities in the model states that the MCNZ 'sets and reaccredits recertification programmes'. We suggest that this could be better worded as 'sets requirements for and accredits recertification programmes…'.

It would be useful for the Council to provide further information regarding the accreditation / re-accreditation standards that will be applied for recertification programmes, and whether it sees these standards as being linked to the principles for recertification (adopted in 2016), or to the core components (outlined in the consultation document).

The NZCPHM believes that a focus on cultural competence and achievement of health equity should be included in all professional development programmes.

We note that this proposal could have made its argument more convincingly by demonstrating the problems it is trying to solve, illustrating these problems by providing examples of where things have gone wrong in the past and providing evidence for the solutions suggested.

The proposal also contains multiple references to the collection and use of robust data. These issues are very much within the scope of public health medicine practice. We consider there may be advantages to the MCNZ in establishing an advisory position within its office for a public health medicine specialist and/or registrar to provide ongoing support for this vital quality assurance work.

We are happy to provide further clarification on any matter covered in this submission.

Yours sincerely

Dr Felicity Dumble
President

New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

8 October 2018

Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
PO Box 10509
Wellington 6143

By email: SConsultation@mcnz.org.nz

Strengthening recertification for vocationally-registered doctors in New Zealand

Dear Carol

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. We note that the current consultation follows on from Council's 2017 consultation on strengthening recertification for vocationally-registered doctors. The NZMA provided substantive feedback on the 2017 consultation;[1] this submission draws on many of the points we made then. While we are pleased that some of our previous concerns appear to have been addressed, we are disappointed that several of the issues we raised appear to have been ignored—particularly those relating to Regular Practice Review (RPR) We elaborate on these concerns in the following paragraphs and provide responses to the specific questions in the consultation.

Overall goals for the changes being proposed and evidence to support proposals

2. We have previously sought clarification on Council's overall goals for the changes related to recertification that are being proposed, as well as evidence for the effectiveness of the proposals Council is advancing. These aspects are important as part of making an effective case for the need for the changes being proposed. While we welcome Council's responses in these areas, we continue to have some concerns around the lack of evidence for proposals that will have major compliance costs.

[1] NZMA. Submission to the Medical Council on Strengthening recertification for vocationally-registered doctors. 19 March 2017. Available from http://www.nzma.org.nz/__data/assets/pdf_file/0005/53618/NZMA-submission-on-strengthening-recertification-for-vocationally-registered-doctors.pdf

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3. While Council believes that recertification is both a quality assurance and quality improvement process, we understand that the overall goal is to provide assurance of the competence of doctors, support the maintenance of high standards of practice and strengthen accountability to the public. Despite sharing a literature review of the evidence relating to recertification activities, we note that Council acknowledges that recertification is an area in which best practice is still emerging, and there remains a significant lack of agreement about the design and form that it should take.

Costs of proposed changes

4. While we welcome Council's recognition of the importance that any change does not create administrative burden, duplication of processes or added layers of bureaucracy for doctors, we continue to believe it is incumbent on the Council, as the regulator, to provide robust external assessments of the financial costs of its proposals. This needs to include the work done by all parties concerned, including the colleges. We reiterate our request for Council to clarify expectations around who is envisaged to bear these costs.

Regular Practice Review

5. Despite our concerns about a 'one size fits all' model, Council is continuing to propose that each medical college will be required to provide Regular Practice Review (RPR) as an option for their doctors. We continue to believe this approach is inappropriate, given the major differences between the colleges in size and resources, as well as types of work and work settings in which their members practise.

6. The NZMA has previously articulated its concerns relating to the proposed use of RPR to inform recertification. These concerns remain relevant. In summary, our main concerns with RPR include the following: i) this is likely to be a very costly process (in terms of both time and money); ii) to the best of our knowledge, there is no solid evidence of efficacy supporting this tool as a way of improving quality; iii) it is not appropriate for all doctors; iv) it may not accurately gauge a doctor's general performance.

7. While RPR may be feasible for some areas of practice, it is impractical for some colleges. We understand that several colleagues have conveyed their concerns with the proposal to provide RPR—even as an option. We reiterate our request for Council to clarify what it envisages by way of RPR for colleges such as the Royal Australasian College of Medical Administrators, the New Zealand College of Public Health Medicine or the Royal College of Pathologists of Australasia.

Use of performance and outcome data

8. While we are supportive of using performance and outcome data from audit of medical practice to inform professional development needs, Council does not appear to have addressed our previous concerns regarding potential confounding factors. We ask Council to explicitly acknowledge the importance of recognising and adjusting for potential confounding factors. These long-established factors include:

- patient factors (eg, age, comorbidities, ethnicity, socioeconomic deprivation, health literacy, diagnostic validity, complexity/severity of condition)
- system factors (eg, diagnostic/interventional facilities, healthcare team factors, supervision, resources vs competing demands, management and governance)
- clinician factors (eg, volume of procedures, training, experience, and case-mix).

Failure to adequately take these confounding factors into account could lead to misleading information that does not reflect the actual competence of any individual named as lead clinician.

Professional development plans and multi-source feedback

9. We note that Council is still proposing the use of a professional development plan (PDP) to guide learning as a core component of a strengthened approach to recertification. While we are generally supportive of PDPs, we continue to have some reservations about the need, cost, value and effectiveness of PDPs for all vocationally-registered doctors. While PDPs may be excellent for younger clinicians who are developing their skills, we reiterate our request for Council to clarify what its expectations are for an experienced expert, particularly when their audits are better than current published figures and they are content working in their limited field?

10. We have previously conveyed our broad support for using the results from multisource feedback (MSF) to inform professional development needs, but only if this is done well and collects feedback from the appropriate number of people. This exercise is likely to entail significant costs. There is also the likelihood of significant selection bias whereby people select only those they know will provide positive feedback. This is even more likely if the information obtained from such feedback is linked to recertification (and therefore, potentially to the person's livelihood). In order to elicit free and frank feedback, we believe that multisource feedback is best conducted in a privileged context. We would welcome recognition of these concerns by Council as it progresses this work.

Ageing doctors

11. We welcome Council's apparent decision to not pursue its previous proposal for mandating certain activities as doctors age. Issues relating to ageing differ across specialties. It is our general view that cognitive assessment should be a continuous informal process for all doctors. We would like to see Council adopt our previous suggestion for further work to ensure retention of the value and contribution of older doctors while recognising and managing changes related to ageing.

Cultural competency and ethics

12. We have previously suggested that cultural competency be incorporated in all recertification programmes. Rather than requiring individual colleges to develop their own cultural competency programmes, we felt that a single programme could be developed and then shared. Likewise, we suggested that the NZMA Code of Ethics should also be incorporated in all recertification programmes. While Council appears to have adopted our suggestion with respect to the NZMA Code of Ethics (by suggesting it be included as part of 'essentials knowledge' for recertification programmes), we contend that Council should also stipulate the need for cultural competency as part of 'essentials knowledge' for all recertification programmes.

Clinician's annual review process diagrams and other feedback

13. We do not support use of the term 'consumer' in these figures and submit that Council replace this term with 'patient' or, where that is not appropriate, 'public', 'people' or 'individuals'. For example, in the first panel in the figure on page 9, we suggest that Council replace 'Consumer' with the term 'Patient'. For the heading of the first column, we suggest Council amend this to 'Public / patient engagement and participation'. With respect to the second figure on page 9, we would welcome clarification on what 'service manager's feedback' means. We suggest Council consider incorporating mention of the Treaty of Waitangi in these figures. With respect to the seventh point on page 6, we believe the word 'should' needs to be replaced by 'must' such that the sentence reads: "Recertification must be supported by employers".

Consultation questions

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

We note that Council is proposing the following key components as a strengthened approach to recertification:

-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.

We are generally supportive of the above components but draw attention to our concerns around regular practice review (see paragraphs 4-6) and professional development plans (see paragraph 8).

2. What suggestions do you have about how these key components could be implemented in recertification programmes?
While RPR may be feasible for some areas of practice, we contend it will be impractical for some colleges (see paragraphs 4-6).

3. Do you foresee any challenges with implementing the proposed approach? What are these and why?
Yes. We foresee major challenges with implementing RPR for some Colleges and/or in some vocational areas. We elaborate on these in paragraphs 4-6.

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?
See our responses to questions 2 and 3, above.

5. Do you think there are any recertification activities that should be mandatory for all doctors?
Yes. Currently, vocationally registered doctors must participate in an accredited recertification programme appropriate to their scope of practice, supported by employers. It would seem reasonable to retain this requirement. The need to base recertification on doctors receiving feedback within an open and supportive culture is also worth preserving.

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?
See our responses to questions 2 and 3, and our concerns with RPR (see paragraphs 4-6).

7. Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?
We are pleased to note that Council appears to have withdrawn its proposal for mandating certain activities as doctors age. We suggest that Council may wish to give specific consideration to requirements for doctors that practice part-time, especially during child rearing, for example.

We hope that our feedback has been helpful and would like to be kept informed of this work as it progresses.

Yours sincerely

Dr Kate Baddock
NZMA Chair

NZOA
New Zealand
Orthopaedic Association

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24 October 2018

Carol Parreno
Strategic Projects Manager
Medical Council of New Zealand
PO Box 10509
WELLINGTON 6143

Dear Carol

NZOA Response to MCNZ Discussion Document on Strengthening Recertification

We have reviewed the MCNZ's discussion document on strengthening recertification for vocationally registered doctors in New Zealand. We consider that the New Zealand Orthopaedic Association (NZOA) CPD programme, Practice Visit Programme and NZOAJR outlier policy contain all the components of the proposed strengthened recertification approach. Copies of the relevant documents are attached for Council's information.

The NZOA CPD programme has been developed specifically to meet the needs of vocationally registered Orthopaedic surgeons working in New Zealand. The programme has been approved by the Branch Advisory Body, the Royal Australasian College of Surgeons. A strengthened CPD programme for surgeons in non-operative practice is being developed for the 2019 reporting year.

All surgeons who perform arthroplasty surgery are required to report to the NZOA Joint Registry. The Registry provides yearly reports which members are required to discuss with their peers. Revision rates for arthroplasty are closely monitored. A six-step process is followed to address outliers. Members are also required to participate in other registries e.g. the ACL Registry, as appropriate.

Following an initial pilot, the Practice Visit Programme has been running since 2012. This is a compulsory element of the CPD programme for surgeons in operative practice and is designed to be a supportive and collegial review carried out in the surgeon's usual practice setting with the intention of improving standards and identifying poor performance. Following the visit participants are graded A-D and where appropriate recommendations are made to improve their practice. Surgeons who receive a visit can claim 20 CPD points for their participation.

A Professional Development Plan (PDP) is included in the NZOA CPD programme. This has been allocated its own section within the online programme to encourage members to develop their own plans.

We welcome confirmation from MCNZ that the NZOA programme meets all the requirements as proposed in your discussion document.

Andrea Pettett
Chief Executive

[redacted]

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Time Spent: 00:06:20

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Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The key components provide solid coverato support the ongoing development of the medical workforce

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Consideration to be given as to how doctors who practice only in the private setting can meet the needs of the recertification process, and in particular those working in sole practice situations. These practitioners potentially pose a greater risk than those working in large DHB or group practices. Ensuring appropriate and robust multisource feedback and peer review practices for these doctors is a key.

Q4 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?

The NZ Private Surgical Hospitals Association (NZPSHA) supports the role of Colleges in recertification processes on the proviso that MCNZ provide sufficient oversight to ensure consistency in content and approach across the spectrum of Specialties.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

NZPSHA strongly believes that recertification activities should not just focus on clinical competencies but should also include quality and behavioural components. The obvious place to incorporate these is into the “Essentials Knowledge” section of the CPD programme. The discussion document proposes including in the Essentials knowledge section aspects such as Code of Ethics, HDC Code of Consumer Rights, HPCA, and HIPC. All of these are important but NZPSHA would like to see these extended to encompass, as appropriate, initiatives such as bullying and harassment (e.g. the RACS “About Respect” programme) and team communication (e.g. ACC Surgical simulator training).

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

NZPSHA would welcome the opportunity for its members to have input into multi-source feedback structures and not to rely solely on feedback from DHBs. NZPSHA members can provide data on infection / complication rates, patient feedback, and comment on performance relating to quality and behavioural factors, We propose that for Specialists working in private facilities, incorporation of feedback from those facilities be made mandatory in any 360° feedback processes. NZPSHA would also like to see a strong approach taken to CME “laggers” which includes notification to any facilities where the Specialist is contracted to or employed by.

Page 2: Submission information

Q8 Your information:

Name	**New Zealand Private Surgical Hospitals Association**
Company	**NZPSHA**
Email Address	**executive.director@nzpsha.org.nz**

Q9 Your position/title:

Executive Director

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

18 October 2018

Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
PO Box 10509 Wellington 6143
Email: SConsultation@mcnz.org.nz

Dear Carol,

Discussion document on strengthening recertification for vocationally registered doctors

The New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to make a submission on the above Medical Council of New Zealand (MCNZ) consultation. We support the MCNZ's Vision and Principles for Recertification, including that the model of 'self-regulation' and approach to recertification needs to be profession-led.

About the New Zealand Society of Anaesthetists
The NZSA is a professional medical education society which represents over 600 medical anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, and trainee anaesthetists. We facilitate and promote education and research into anaesthesia and advocate for the professional interests of our members and the safety of their patients. As an advocacy organisation we develop submissions, work collaboratively with key stakeholders, and foster networks of anaesthetists nationwide. The NZSA, established in 1948, also has strong global connections, and is a member of the Society of the World Federation of Societies of Anaesthesiologists (WFSA).

Overview
The NZSA strongly supports developing a practical and effective pathway to strengthen CPD so that doctors remain competent and up to date throughout their working lives to deliver optimal care for their patients. We concur with the MCNZ that recertification changes must be profession led to ensure they are appropriate to scope of practice, meaningful and add value to a medical practitioner's professional development and practice. Additionally, we wholeheartedly endorse an evidenced based, rather than time based, approach.

Standards and CPD requirements for anaesthetists
The Australian and New Zealand College of Anaesthetists (ANZCA) sets the standards for training anaesthetists and determines the profession's knowledge requirements. The ANZCA CPD programme is arguably one of the most comprehensive among medical colleges and covers most aspects of what is considered valid to assess. The CPD portfolio, which the college mandates, is in line with MCNZ proposals, including a personalised learning plan. Annual, in-house peer review of practice is also an option under the college's CPD and useful for anaesthetists, particularly as many tend to practise in a degree of isolation. ANZCA provides templates and guidelines to help doctors identify learning needs and plan

continuing professional development, and also provides resources for specific career stages, such as *PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists*.

Peer Review and audit
It is our impression that many are partaking in this activity and find it very worthwhile. The ANZCA CPD programme strongly aligns with the MCNZ's proposed approach to peer review. We support the position however that peer review not be mandatory. A worthwhile area that we encourage MCNZ to consider is mandatory clinical supervision for addressing physician wellbeing, which is mandated by other professional groups. It is widely recognised that physician wellbeing correlates very strongly to quality patient care.

We also strongly support removing the initial MCNZ proposal for compulsory audit.

Cultural competence
We fully support the MCNZ's inclusion of cultural competence as part of the skills, knowledge and attributes required under recertification and CPD. This is especially pertinent in helping to address health inequities in our health system. We would suggest however that a broader definition than that provided by MCNZ for cultural competence be included and refer you to ANZCA's Cultural Competence Position Statement 62, which is incorporated into our CPD programme. This stipulates the following requirement: "Participants explore culturally different expectations for clinical communication/behaviour, to develop strategies for responding effectively when expectations differ between colleagues, patients and their family members/carers." The broader aspects of cultural competence should also encompass communication and interactions between health professionals, to address negative and disruptive behaviours such as bullying.

Regular Practice Review
We are pleased that MCNZ has taken on board stakeholder feedback, including that of the NZSA and the College, that regular practice reviews should be offered and encouraged, but remain optional.

CPD and ageing doctors
We welcome the decision not to pursue the MCNZ's previous proposal for mandating certain activities as doctors age. Regular CPD should be sufficient to maintain standards for ageing doctors. Competency should be assessed for all groups and not be ageist. However, practitioners should recognise that planning for retirement is an integral aspect of career planning and medical colleges should be part of raising awareness of changing capabilities as a doctor ages, with support available if required. We believe that all medical colleges should have recommendations in place for ageing practitioners to support them in their practice, and to uphold patient safety.

Evidence based recertification activities
In our previous submission on recertification (May 2017) we asked MCNZ to ensure that its proposals for recertification are evidence based to ensure that they are valuable and of the greatest benefit and urged international literature to be evaluated. We commend MCNZ for taking this approach and providing the results of a literature review in its discussion paper. This review has highlighted effective activities to influence changes in practice and improved patient outcomes, such as multisource feedback from colleagues, peer review, focusing

learning in response to identified needs, interactive education, and an appropriate professional development plan.

Achieving objective measures of competence is well underway with new assessment tools in development, including simulation and advances in virtual mechanisms which enable faster, more flexible and timely educational opportunities. We note however that MCNZ acknowledges that recertification is an area in which best practice is still emerging, and therefore there remains some uncertainty as to the optimal design of recertification.

Further research is needed to look at effective and feasible tools of assessment.

MCNC discussion paper questions and answers

What are your thoughts about the key components of the proposed strengthened recertification approach?
We are supportive of the key components and are pleased that proposals to make audit and RPR mandatory have been removed. The proposal is strongly profession-led and puts the responsibility back on the college.

What suggestions do you have about how these key components could be implemented in recertification programmes?
The key components are already in place for ANZCA, which has a very robust CPD programme.

Do you foresee any challenges with implementing the proposed approach? What are these and why? 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?
No. Our programme is already in keeping with the recommendations.

Do you think there are any recertification activities that should be mandatory for all doctors?
We believe that the review of a medical practitioner's practice should be mandatory, but not the format i.e. not insisting on regular peer review.

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?
We already have peer review as an option, so there are no issues. The College CPD programme is robust and of a high quality.

Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?
No.

We are supportive of ANZCA's submission.

Thank you for the opportunity to comment. We are happy to answer any questions on our submission if required.

Yours sincerely

Dr David Kibblewhite
President

26 October 2018

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Carol Parreno
Strategic Project Manager
Medical Council of New Zealand

By email: SConsultation@mcnz.org.nz

Dear Ms Parreno,

Re: your discussion document "Strengthening recertification for vocationally-registered doctors in New Zealand"

Thank you for your email dated 18 October 2018 providing the opportunity to comment on the discussion document "Strengthening recertification for vocationally-registered doctors in New Zealand". The Commissioner has asked me to reply on his behalf.

The Health and Disability Commissioner is charged with the role of promoting and protecting the rights of health and disability consumers as set out in the Code of Health and Disability Services Consumers' Rights. The overarching goal of your recertification programme: providing assurance that doctors are competent, supporting the maintenance of high standards of practice, and strengthening accountability to the public are very relevant to the work of the HDC. I note that this relevance is reflected in your "Visions and principles for recertification".

This Office provided comment on the draft of "Visions and principles for recertification of doctors in New Zealand" in October 2015. I would be grateful if you could keep us updated as the recertification process is developed. We look forward to ongoing involvement.

Yours sincerely

Jane King
Associate Commissioner, Legal

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26 October 2018

ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

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Attention: Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
sconsultation@mcnz.org.nz

Dear Carol

Re: Feedback – Strengthening Recertification for Vocationally Registered Doctors in NZ

Thank you for the opportunity to provide you with feedback based on the MCNZ discussion document, 'Strengthening recertification for vocationally registered doctors in New Zealand', September 2018.

The Royal Australasian College of Medical Administrators (RACMA), now in its 51st year of operation, is unique in the world as a specialist medical college training medical leaders. RACMA has members in Australia, New Zealand and other parts of the world and in key leadership roles throughout all aspects of the health care system influencing the health outcomes for Australian and New Zealand patients.

We have liaised with the RACMA Continuing Education Program Committee and our New Zealand Jurisdictional Committee and are pleased to provide the following feedback based on the discussion questions outlined on page 15 of the document:-

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

   - We agree with the proposed core components of the strengthened approach and in particular the profession-led approach that will take into account roles in varied workplace situations.
   - We are in support of the prescriptive approach from both participant and regulator perspective.
   - We support flexibility to decide and develop appropriate programmes (within an agreed recertification framework) that is relevant to each professional group.

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

   - A standardized PDP plan across Colleges could be a consideration to assist in consistency of approach and the potential for the use of one plan in particular for doctors who hold dual/multiple Fellowships. This would allow multiple Colleges to recognize one PDP as long as the development plan was cognizant of the various Scopes of Practice if applicable.

- RACMA believes a strengthened embedding and understanding of role competencies and scope of practice will assist members to determine what professional development is best linked to the practice of medical leadership. This is of particular importance for members who hold dual fellowship to ensure that they self-assess their professional development against the appropriate medical leadership standards.
- MCNZ should work with the specialty medical colleges on a streamlined system of mutual recognition of programs whether delivered by the medical colleges or other recognized education providers and form part of the implementation process for the recertification program.

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

- Medical administrators often fill unique roles that can create a challenge to find a peer to undertake traditional peer review and audit. This document is an excellent guide to follow.
- Recertification program may represent a significant change for a large majority of practitioners; therefore; a considered change management strategy will be important. Early engagement with key stakeholders and professional bodies will be critical.

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?**

- MCNZ need to consider that many Colleges are trans-Tasman and that aligning CPD requirements with the Medical Board of Australia's introduction of the Professional Performance Framework would be advantageous.
- Implementing the outcomes of this review could be well supported by the development of a suite of support material that provides example activities, tools and templates.

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

- RACMA recognizes the importance of recertification activities and that some must be mandatory however we also believe that consideration should be given to ongoing and regular review of recertification activities that affect patient outcomes and quality improvement. To ensure relevance, continuous review should be undertaken to ensure that required activities are responsive to health setting needs. This would include identifying priority areas such as cultural safety and bullying and harassment for example that are important now but should not become mandatory activities on an ongoing basis.

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?**

    - As mentioned in our feedback at question 3, RACMA members generally hold unique roles within the health care setting and activities such as peer review can pose challenges. We would welcome further consultation on how we can make this a more effective activity for members.

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

    Change management activities require opportunities for feedback as part of the consultation process. We would suggest that consideration be given to developing a detailed communications plan with realistic timelines for implementation. A transition period for moving into the new framework should also be a consideration.

We would like to commend the MCNZ on their approach to the consultation phase and thank you for the opportunity to comment on the discussion document.

If you would like to discuss any of the feedback provided above, please contact Debbie Greenberger, Membership Manager directly on +61 3 9088 7964 or via email dgreenberger@racma.edu.au.

Kind regards

Melanie Saba
Chief Executive

8 November 2018

Ms Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
PO Box 10509
The Terrace
Wellington 6143

SConsultation@mcnz.org.nz

Dear Ms Parreno

MCNZ Consultation on recertification in New Zealand

Thank you for this opportiunity for the New Zealand National Board of the Royal Australasian College of Surgeons (RACS) to comment on the MCNZ's consultation document on this matter.

RACS is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. It is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees across nine surgical specialties: cardiothoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology head and neck surgery, paediatric surgery, plastic & reconstructive surgery, urology, and vascular surgery. Approximately 95 per cent of all surgeons practising in New Zealand and Australia are Fellows of this College (FRACS). Its training and recertification programmes are accredited by the MCNZ and by the AMC and Medical Board of Australia

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and, as part of this commitment, strives to take informed and principled positions on issues relevant to surgery. The recertification requirements set by a regulatory authority, in this instance the MCNZ, for vocationally registered surgeons is one such issue.

The comments below are in response to questions posed by the MCNZ.

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

RACS is supportive of the MCNZ's approach to strengthen recertification in New Zealand. We believe that the key components of continuing professional development or recertification are:

- Peer Reviewed Surgical Audit
- Clinical Governance & Quality Improvement
- Maintenance of Knowledge and Skills
- Reflective Practice

RACS agrees that the individuals' recertification needs to be related to the clinician's scope of practice and the actual work that the individual is undertaking.

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

RACS agrees that the key components be:

- 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.

When developing recertification programmes, providers determine what the most relevant and valuable activities are for their scope of practice.
Colleges and approved recertification providers are appropriate to determine what is appropriate for practitioners under their jurisdiction. Providers' programmes need to be accredited by the MCNZ.

Recertification programmes are based on evidence and utilising data that informs what the most valuable activities are for the doctor.
Providers of programmes should be determining which data sets are used for recertification programmes under their jurisdiction. Data sets need to be able to identify outliers in terms of performance; and these outliers need peer review and remediation as appropriate.

Recertification programmes are relevant to the doctor's actual workplace and career plans.
RACS supports assessment and review in the workplace as relevant components of recertification; and supports collaboration between employers and the providers of recertification programs so as to minimise duplication of activities.

Recertification programmes include use of a PDP to guide learning and development.
RACS supports the forward planning of recertification activities in the form of a development plan outlining what activities are planned for the next recertification cycle.

All providers offer RPR as an option in recertification programmes for their doctors.
RACS supports peer review of workplace activities as an optional activity. These reviews need to be specialty specific, peer driven and multidimensional. The evidence for the effectiveness of practice visits to change performance needs to be ascertained before making this option mandatory.

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.
RACS agrees with this approach.

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

Implementing enhanced or strengthened recertification programmes are time and resource consuming and need to be built into the individuals work schedule and as an integral part of employment. RPR require a large organisational component and this needs to be recognised.

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?

The MCNZ should provide a framework and guidelines for the individual and key components of a recertification program that can then be tailored to individual practitioners.

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

RACS belies that what needs to be mandatory is that accredited key elements and 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.

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?

Peer reviewed audit of procedural outcomes is a key element of RACS members recertification in addition to peer review of non-technical skills. RACS recommends Regular Practice Reviews be provided as an option; but does not object to individual specialty groups making this mandatory for its members.

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

RACS recommends a graduated implementation of any changes to a recertification programme.

Thank you again for this opportunity to comment. RACS looks forward to learning of the MCNZ's decisions on its requirements for recertification programmes.

Yours sincerely

Nicola Hill FRACS
Chair
New Zealand National Board

The Royal Australian & New Zealand College of Psychiatrists
Te Te Akaaka Roa
New Zealand National Office

Your Health in Mind

24 October 2018

Ms Carol Parreno
Strategic Project Manager
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By email: SConsultation@mcnz.org.nz

Tēnā koe Ms.Parreno

Re: The Medical Council of New Zealand's Discussion Document 'Strengthening Recertification for Vocationally Registered Doctors'

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to respond to the Medical Council of New Zealand's discussion document on *'Strengthening Recertification for Vocationally Registered Doctors'* (the document).

The Health Practitioners Competence Assurance Act, 2003 was developed *'to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent'.* Recertification is one method of meeting this social contract. The public must be satisfied that a doctor's recertification activities address those principles that underpin a therapeutic relationship between the patient and the doctor. These principles are at the core of recertification and the proposed model put forward by the Medical Council of New Zealand (the Council) will continue to uphold these values.

We understand that CPD, medical educational or recertification activities must be relevant to the doctor's scope of practice and therefore doctors have an obligation to remain competent in their field of medical practice. While there are general guidelines and principles that underpin medical education, recertification or CPD, there are specific skills, knowledge and practices that must be recognised at a speciality level. For these reasons, we concur with the Council that medical colleges are best placed to develop recertification programmes to meet the needs of their members and support them to remain competent medical practitioners.

The RANZCP has previously provided feedback on your earlier consultations on recertification, in 2015 and 2017, and we reiterate our support in regards to the Council's vision and principles regarding recertification.

We contend that College's CPD aims are well aligned with the Council's principles that promote flexibility within a CPD framework but still includes elements, such as peer review and/or audit, where there is demonstrated evidence that these activities contribute to overall practitioner competence.

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In Response to your Specific Questions

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

The RANZCP has previously signalled support for the Council's approach to recertification. Below we have provided commentary on the Council's six components that we consider would strengthen the current recertification framework.

1.1 Recertification is profession-led and appropriate to scope of practice

This principle ensures that medical colleges are able to develop recertification programmes that best meet the needs of their members and align with that particular medical speciality's practice of medicine. For example, a doctor practising a highly procedural-based speciality may require a slightly different CPD programme compared to psychiatry, public health or medical administration. The RANZCP supports the Council's proposal that allows the medical colleges some flexibility in developing recertification programs relevant to their members' needs.

We note that other jurisdictions such as the General Medical Council have developed a very prescriptive approach to recertification or revalidation. As a consequence some UK doctors remain concerned about many aspects of the revalidation process e.g. viewing the process as highly bureaucratic and detracting doctors from their medical practice (Archer, 2017). In contrast, the Medical Council of New Zealand has taken a formative approach to regulation.

The RANZCP maintains that medical colleges are best placed to understand which CPD activities would best support and build on the college's curricula, standards and practice guidelines.

1.2 Increased emphasis on evidence, value of activities & peer review–based.

The RANZCP encourages members to engage in CPD that is broad based allowing members to keep abreast of a wide range of knowledge and skills and facilitating member opportunities to develop in other directions if necessary. We note that workplaces or types of practice may change and that CPD activities must reflect good clinical practice and professionalism including ethics and cultural competence. We support an evidence-based approach but note that the importance of supporting innovation in practice must be encouraged through participation in improvement activities.

We maintain that if practitioners are to engage and benefit from recertification activities then there must be good evidence supporting the positive impact on patient care and on the practitioner's behaviours, competencies and skills.

We appreciate the literature review provided by the Council that further identifies those CPD activities that are most effective to improving doctors' skills, knowledge and practice which contribute to better patient care.

1.3 Education and development relevant to workplace and career planning

We support the emphasis on reinforcing the value of undertaking CPD activities that are relevant to the place of work, specialty, clinical practice and career paths.

In those medical specialties where significant physical demands are placed on a doctor, it may be appropriate for older doctors to spend more time in mentoring, training and supervisory roles and their CPD goals and activities would reflect this change in role. We support doctors regularly reviewing their PDP (Professional Development Plan) so it is aligned with their career and life-stage objectives, e.g. semi-retirement, moving into another medical speciality or into leadership roles.

When a doctor engages in CPD activities that inform practice and contribute to improving knowledge and skills, we consider the role of CPD is to facilitate application of practice to provide more effective care for patients and potentially better outcomes. We expect that employers would encourage and support doctors to engage in CPD that is relevant to their practice and working environment.

1.4 Use of Professional Development Plan (PDP) to guide learning

The RANZCP supports PDP as an essential CPD tool and consider the process of planning, doing, reflecting and reviewing CPD/ recertification activities is invaluable for targeting learning goals and assessing the effectiveness of care to improve quality and patient outcomes (RANZCP, 2018).

The RANZCP recommends that individuals review their PDP periodically through the annual CPD cycle to ensure relevancy of the PDP to their current clinical practice, role within the service e.g. management and leadership roles, patient mix and environmental context. We require members to spend 5 hours annually on developing and reviewing their PDP. We produce guidelines including a sample PDP[1] and other supporting materials to guide CPD participants in meeting this requirement (RANZCP, 2018).

1.5 Offering regular practice review (RPR)

The Council proposes that all recertification providers offer RPR as an option for their doctors. We support the proposal for RPR to remain an optional recertification activity and that all recertification providers offer some form of a RPR. We note the evidence from the Malatest study, conducted with general registrations, indicates that RPR can impact positively on a doctor's practice and suggests that changes based on the RPR findings are maintained over time (Malatest, 2017).

We support the Council's suggestion[2] that Regular Practice Review's be renamed as "Regular Practice Visits". Within our CPD program we already provide members with the option of undertaking a Practice Visit, which emphasises the formative nature of this activity and sends a clear message to participants that it is not summative. (RANZCP, 2018). The RANZCP notes that historically few psychiatrists have participated in a Practice Visit. We are currently examining ways of strengthening this activity within our CPD Programme and intend to promote it to our members.

While the RANZCP supports optional RPR consideration of the place of RPR within the doctor's wider workplace context is important, noting that a hospital-based doctor may also be involved in appraisal and credentialing activities. We are willing to work with the Council to find ways to reduce duplication as this has time and resource implications for the health professionals and the health system.

The impact of making RPR mandatory will be additional work for the medical colleges and may not be suitable for all branches of medicine e.g. public health medicine and all practice settings e.g. medical administration. If made mandatory the intent of RPR may be lost by potentially blurring the boundaries between a formative or summative CPD process. We note that mandatory RPR policy will be counterproductive as medical colleges would be required to report back on those doctors who had not satisfactorily completed an RPR.

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[1] See page 12 of the RANZCP CPD Program Guide

[2] As proposed at the recent Annual Medical Council Meeting on 11 September 2018.

1.6 Specified CPD hours and type

We note the Council is proposing to move to an evidenced-based CPD framework rather than a time-based approach. We suggest that the current structure is retained with a set number of overall hours e.g. 50 hours per annum but with a stronger emphasis on the value of peer review/audit e.g. those CPD activities are more likely to contribute improving practitioner knowledge and skills.

The Council has outlined that peer review and audit, CME and knowledge-based activities be proportionally assigned to an overall CPD programme. While this approach allows a certain level of flexibility, it may be difficult for the medical colleges to monitor their members' CPD activities and to ensure there is consistency of CPD activities across the particular profession.

The RANZCP would not support an Essentials test/ module because of the variability in the work undertaken by specialist psychiatrists. The RANZCP has developed a range of modules within the Learnit3 online platform that can address members' learning some at a basic level and some addressing specialised topics and clinical presentations.

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

The proposed changes would not be difficult to implement within the existing CPD framework the RANZCP has in place. We have outlined within our responses provided 1.1 to 1.6 that relate to particular issues we have identified with the Council's proposed approach to recertification.

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

Developing a recertification process that does not create a burden for doctors and their employers is a challenge. There are already several regulatory requirements operating within the health sector that confirm doctors are practising within scopes of practice e.g. credentialing and accreditation procedures alongside HR (Human Resource) processes e.g. employment appraisals. Recertification requirements should not add another layer of compliance. Consideration should be given to reduce duplication of effort. The CMC's '*A Best Practice Guide for Continuous Improvement'* addresses this issue in some detail and notes the potential for higher compliance costs for doctors involved in multiple activities.

A recent Council discussion with the medical colleges highlighted how external data sources can be used to inform CPD audit activities to improve practitioner performance, and patient outcomes. The RANZCP notes that psychiatrists do not have access to nation-wide benchmarking data sets to enable a meta-analysis of patient outcomes. Doctors practising in procedural specialities do have access to clinical registries and clinical audit data which enables individual comparison of outcomes against that of colleagues practising in similar circumstances. We contend the Ministry of Health and/or with the Health Quality and Safety Commission have a role in providing better access to clinical outcomes data to inform quality improvement initiatives.

Obtaining feedback from patients, as part of the quality feedback cycle, is an important activity in identifying gaps in practice. The RANZCP highlights difficulty in obtaining qualitative data from psychiatry patients due to their mental state. A study in the United Kingdom noted that patient characteristics inhibits the collection of feedback data (Umbrella Study, 2016).

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[3] The RANZCP's online learning platform for CPD activities. It includes a wide range of resources including online courses, podcasts, interactives learning modules, webinars, videos etc.

We also note there are some pitfalls in placing an emphasis on quantitative data sets as very often doctors work in multidisciplinary teams and all practitioners contribute to a patient's care. These types of confounders would need to be considered when using external data sets to inform the doctors' practice and CPD activities.

4. **Are there 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?**

   In implementing the proposed recertification programme there may be resource implications for the smaller medical colleges, for example, they would need to offer RPR/practice visits. The design and delivery of a practice visit programme would take considerable time and funding. Medical colleges are funded from membership subscriptions therefore requiring all medical colleges to 'offer' RPR would need to be phased in over a number of years to build time and resources to meet this obligation.

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

   If CPD activities are to be mandated then the RANZCP considers it must be based on strong evidence underpinning the effectiveness of the approach in changing doctors' practice and improving patient care.

   The RANZCP suggests that all CPD programmes include peer review or audit. Since 2017, it has mandated that members undertake some form of audit as a formative process. We encourage our members to undertake a range of practice improvement and quality assurance activities such as practice visits or join a peer review group.

   The RANZCP has developed a hybrid model that ensures the focus of CPD activities are evidence-based but still allows flexibility in other activities to meet specific members' learning needs. We have very clear compulsory segments within our programme e.g. PDP (5 hours), peer review group (10 hours), practice development, quality improvement and review (5 hours) (RANZCP, 2018). We advocate for continued flexibility therefore we do not support too many compulsory sections within a recertification programme.

   We do however, suggest that a cultural competence activity is mandated within the recertification programme. We note that the Australian Medical Council has introduced five specific accreditation standards relating to cultural competence. This is clearly indicates that being a culturally competent practitioner is an important requirement in delivering optimal patient care (MCNZ, 2017). We believe all doctors practising in New Zealand should be working towards improving their understanding of Māori, their health needs, and focusing on reducing health inequities.

   The Council has stated that they are committed to developing cultural competency frameworks and relevant standards that can be used in recertification programmes (MCNZ, 2017). The Council, working with Te Ora, has clearly articulated that doctors need to understand how culture influences health outcomes and consider possible solutions to the current inequities experienced by Māori (MCNZ, 2017A). This kaupapa needs to be progressed by mandating a relevant recertification activity. A number of medical colleges, including RANZCP[4], already support their members in improving their knowledge, skills and understanding of cultural competence. The Council has also produced a number of resources[5] that provide a foundation for doctors to develop an understanding of Māori and Pacific peoples and recognise their specific health needs. There is a wide range of supporting materials making it possible for doctors in any speciality to include a cultural competence activity within their CPD activities.

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[4] For example the RANZCP has a kaumātua and kuia available to guide our work in regards to cultural competency and a Māori Mental Health Committee - Te Kaunihera.

[5] For example, "Best health outcomes for Māori: Practice implications"

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?**

   The RANZCP CPD framework places significant emphasis on formal peer review activities. We also encourage our members to participate in a range of peer review activities, including peer review groups, practice visits and supervision.

   We note that Peer Review Groups remain an important recertification activity for psychiatrists. The RANZCP currently has 157 Peer Review Groups operating within New Zealand.

   We provide our members with substantial support in order to assist participation in peer review programmes.[6] The RANZCP does not foresee any issues for our college in offering RPR as an option for our members however we have highlighted some potential issues with RPR under 1.5.

7. **Do you have any comments or suggestions about proposed approaches that might assist with a smooth implementation?**

   To allay concerns about the proposed recertification approach and any changes, we suggest that it is well communicated to all doctors practising in New Zealand.

8. **Additional Comments**

   A doctor's own health requires greater emphasis within the recertification programmes. One of the reasons doctors are obligated to engage in recertification is to improve patient outcomes but an unwell doctor is not well placed to deliver optimal care. In New Zealand there is evidence indicating that doctors may go to work even when unwell and that many experience burnout. In addition widespread bullying in medical settings contributes to poor mental wellbeing. Peer review activities and Practice Visits provide an opportunity in a supportive environment to address the doctor's own health. The RANZCP supports the Council's "Good Medical Practice" which notes, "*you [doctor] should register with an independent general practitioner so that you have access to objective medical care"* (MCNZ, 2016).

   We believe CPD activities need to include some reference to the doctor's health and identification of CPD activities that might contribute to addressing potential challenges in a doctor's practice. A recent survey noted that a high proportion of senior doctors are experiencing burnout and evidence suggests a strong association between burnout and poor clinical outcomes (ASMS, 2016). The General Medical Council has specifically included information regarding the individual doctor's health status in their revalidation process. We suggest that the MCNZ investigate how doctors' health might be addressed through development of a CPD activity to help doctors become aware and be proactive in reducing health risk (CMC 2013).

   We note that the majority of medical colleges operating in New Zealand are bi-national therefore any policy change relating to recertification must be cognizant of the regulatory environment and revalidation/ recertification processes operating in Australia and New Zealand. We note there are differences in approach to recertification given legislative and practice differences but identifying synergies would reduce the burden of CPD overlap between New Zealand and Australia.

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[6] Pages 13 to 17 CPD Program Guide 2018.

Thank you for the opportunity to provide feedback on the Council's document.
If you require further information regarding this submission, please contact the RANZCP's National Manager, New Zealand, Rosemary Matthews who supports the New Zealand National Committee – *Tu Te Akaaka Roa*. Rosemary can be contacted on 04 472 7265 or by email Rosemary.Matthews@ranzcp.org.

Ngā mihi

Dr Kym Jenkins
President

Ref: 1271o

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19 October 2018

Carol Parreno
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Medical Council of New Zealand

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Dear Ms Pareno

Re: Strengthening Recertification Discussion Document

Thank you for inviting the Royal College of Pathologists of Australasia (the College) to review the above document. The College would like to make the following comments.

1. Key components

With respect to consumer engagement and participation (p9): the College does not understand how 'Consumer council/ membership input at key committees' relates to the clinician's annual review process? Are the committees within the College? Or within the DHB? How will they garner feedback for annual reviews on individual clinicians? How does this relate to pathologists who don't have direct contact with patients?

2. Implementation

Fellows could determine their learning goals within the development of a professional development plan and tailor it to their particular subspecialty interest.

3. Challenges

The first four proposals (p11 onwards) seem sound. Proposal 5 regular practice review is untenable in the current workplace. A small College cannot afford to have Fellows travelling around the country visiting other Fellows. These conversations are unlikely to provide useful feedback and will ultimately be a check-box exercise at great expense. Within Pathology IANZ already conducts regular laboratory visits using internationally recognised standards. The addition of further visits in pathology is not supported.

4. Professional development Plans

Professional development plans, by their inherent nature are specific to the pathologist concerned. This again, is not something our College could provide. Templates or examples can be provided on the College website and potentially incorporated into the current CPD requirements but the College cannot oversee and provide this for all the Fellows.

Proposal 6: Essential knowledge items should be provided by the medical council or the medical council should indicate what standard is required for these - in particular Treaty of Waitangi, cultural competency, Privacy etc. These are NZ specific and how will the MCNZ deem them appropriate?

5. Our Fellows already undergo regular peer review in form of internal quality assurance activities and external proficiency testing. Asking for a face-to-face conversation yearly for all Fellows is not appropriate.

If you have any further questions or comments please do not hesitate to contact Dr Debra Graves CEO RCPA at debrag@rcpa.edu.au.

Yours sincerely

Dr Debra Graves
Chief Executive Officer

RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

26 October 2018

Carol Parreno
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Sent via email: SConsultation@mcnz.org.nz

Dear Carol,

Towards strengthening recertification for vocationally-registered doctors in New Zealand Discussion Paper

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) supports the development of a process that supports medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine, termed recertification. We welcome the opportunity to comment on the strengthening recertification in New Zealand discussion paper.

RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy. Underpinning all of RANZCO's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the general public in all matters relating to vision and the health of human eye and advocates for accessible ophthalmology cost effective service for patients.

We respond to each discussion question in turn below:

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

   We agree with the outlined key components; however, we would like more information regarding point 5 'offering regular practice review (RPR)'. Is it expected of medical colleges to organise and conduct RPR for doctors, or just accept RPR towards recertification?

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

   CPD Committees with input from Fellows can identify the most appropriate activities for their specialties.
   The MCNZ should set minimum standards that can be adapted to suit each specialty.

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

This approach must be incorporated in to the current CPD program, streamlined and managed by Colleges for their members. Likely implications include:

- Increased burden of managing College CPD programs. Will there be funding for technical and human resources to manage this?
- Colleges may be seen as the 'police' by their Fellows rather than supporting Fellows.
- Colleges do not currently have the resources to conduct performance reviews or outcome measurements outside of existing CPD programs.

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

We agree in principle, but the model must be introduced appropriately with the available resources to minimise impact on patient care. The RANZCO CPD program already includes many of the proposed activities, however we are concerned about the detail of the model, specifically:

- How would performance reviews be conducted? Who determines who does the review? If the practitioner decides, then there will likely be positive bias introduced into the process.
- Who measures the outcome or chooses what is measured? If the practitioner gets to choose then they would not choose to measure anything they are likely to be underperforming in. If chosen externally who will choose what is measured and how and who will enforce it?
- Who will validate educational activities? Who will pay for it?
- If multi-source feedback (MSF) is to be used, then feedback from patients should be focused on non-technical skills such as communication, professionalism, ethics, etc.
- The program will result in increased cost, time and human resources for Colleges to implement and monitor.
- Potential resentment from practitioners.
- Potential over-representation of non-compliant practitioners because they haven't had the time to complete the requirements of the new process. This would result in more unnecessary bureaucracy chasing up or auditing these practitioners.

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

We believe that professional development plans for CPD with reflection are important for doctors as part of recertification. Planning mandatory audit and reflective activities such as attendance at morbidity and mortality type meetings ensures doctors are invested and motivated in their own professional development.

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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?**

   The RANZCO CPD program currently provides resources for Fellows to complete self-organised peer review practice visits between colleagues. This programme has proven to be an effect method of peer review with our Fellows. The primary concerns with RPR:

   - How would RPR be conducted? Who determines who does the RPR? If the practitioner decides, then there will likely be positive bias introduced into the process.
   - Who measures the outcome or chooses what is measured? If the practitioner gets to choose then they would not choose to measure anything they are likely to be underperforming in. If chosen externally who will choose what is measured and how and who will enforce it?
   - If multi-source feedback (MSF) is to be used, then feedback from patients should be focused on non-technical skills such as communication, professionalism, ethics, etc.

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

   Following the MBA proposition of Professional Performance Framework, the RANZCO CPD Program has been strengthened. This incorporates the principles MCNZ proposes. RANZCO anticipates a smooth implementation.

Thank you for the opportunity to comment on the revalidation in Australia discussion paper. Please contact RANZCO Senior Manager - Education Standards, Simon Janda, at sjanda@ranzco.edu for any enquiries or further information.

Yours sincerely,

David Andrews
RANZCO CEO

The Royal Australian and New Zealand College of Radiologists®

26 October 2018

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Re: Medical Council of New Zealand's Discussion document, "Towards strengthening recertification requirements for vocationally-registered doctors in New Zealand".

Thank you for the opportunity to provide feedback regarding the Medical Council of New Zealand's (MCNZ) Discussion document, "*Towards strengthening recertification requirements for vocationally-registered doctors in New Zealand".*

The Royal Australian and New Zealand College of Radiologists (RANZCR) is a specialist medical college with 615 Fellows actively working in New Zealand. RANZCR administers training programs for admission into the practice of clinical radiology and radiation oncology, accreditation for overseas-trained specialists, and a continuing professional development program for Fellows. There is a total of n=533 Clinical Radiologists and n= 82 Radiation Oncologists currently working in New Zealand. Professional networks for Radiation Oncology are small, with many practitioners working in the same clinical setting. Whilst the number of Clinical Radiologist is much larger than their Radiation Oncology counterparts, the profession has similar restrictions through the growing number of sub-specialists and therefore small networks of similarly skilled professionals.

The MCNZ discussion document outlines the vision and principles underpinning recertification for vocationally registered medical practitioners, in New Zealand. RANZCR broadly accepts the principles set out in the discussion document and their role in informing best practice in medical education, training and quality improvement. We have contextualised the principles for our members within the New Zealand landscape and would like to submit the ensuing feedback regarding the implementation of Regular Practice Reviews, specifying CPD hours/type and the need for continuous engagement with the employers of medical practitioners

Regular Practice Review

RPRs have been acknowledged as a supportive and collegial review of a medical practitioners' practice. Conceptually, RPR offer both opportunities and challenges for RANZCR. The quantifiable practice of clinical radiology and radiation oncology is delivered within a multi-disciplinary environment and therefore is subject to constant peer review. For this reason, we believe the proposed benefits of RPR would provide only marginal results.

Further, to facilitate such reviews would present significant operational challenges for RANZCR. Substantial work will be required to establish the infrastructure required to enable the implementation of RPRs, for a largely marginal benefit. This will include the necessary policy and clinical governance considerations, in addition to human and fiscal resources to facilitate a successful program.

Most RANZCR Fellows have acknowledged the benefits associated with accountability based professional development such as those offered through RPRs, clinical audits and peer reviews. Despite this, the small cohort of RANZCR Fellows and subsequent finite professional networks have the potential to produce biased outcomes, limiting the integrity of the process.

Specified CPD hours and type

MCNZ have suggested a structured approach to the registration of CPD hours by type of activity, rather than time to reflect the value to the practitioner. Whilst RANZCR acknowledge the rationale behind this proposal, we are wary that the Medical Board of Australian (MBA) have proposed the introduction of a contrary hours-based recognition scheme within their Professional Performance Framework.

For RANZCR, who support members across both Australia and New Zealand, the need to deliver asymmetrical CPD points recognition schemes would prove problematic. We anticipate this angst will be shared by other medical colleges who support members in both countries. Moving forward, we support ongoing collaboration between MCNZ and MBA to ensure consistency in the approach to accrual of CPD points, that acknowledges the educational value offered from CPD activities appropriately recognizing time and type of activity.

Employer engagement

RANZCR supports the implementation of quantifiable measures to assess and monitor the performance of medical practitioners. However, the capacity for practitioners to progress the integration of mechanism such as clinical audits, comparative data set analysis and clinicopathological correlation meetings rely on the support of employers such as hospitals, District Health Boards and Private entities, to facilitate access to the data and statistician support required.

RANZCR supports efforts by MCNZ made to date to engage employers of medical practitioners and advocates continued engagement to facilitate adequate availability of data for educational and training purposes.

RANZCR thanks the MCNZ again for the opportunity to contribute to the discussion document, *"Towards strengthening recertification requirements for vocationally-registered doctors in New Zealand".* Please contact me directly on +61 2 9268 9730 or E shona.dutton@RANZCR.edu.au if you would like to discuss the recommendations provided in this submission.

We look forward to an ongoing engagement through the introduction of educational reforms.

Yours Sincerely,

Dr Gabriel Lau
Chair, New Zealand Branch
Royal Australian & New Zealand College of Radiologists

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, October 25, 2018 3:27:00 PM
Last Modified: Friday, October 26, 2018 3:38:37 PM
Time Spent: Over a day

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

[redacted] is in agreement that providers be able to develop their recertification programs using an evidence-based, rather than time-based approach. [redacted] notes that the Council would not stipulate how recertification programs would be structured and supports this approach. [redacted] s in agreement that a flexible approach to recertification programs is appropriate. Of particular importance is that Specialist Medical Colleges have the flexibility to decide and develop a program appropriate for their professional scope. [redacted] agrees with the proposal that Medical Colleges offer RPR as an option (rather than mandatory requirement) within their recertification program.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

As some of the proposed components would take considerable time and resources to implement, Specialist Medical College would need to be supported by provision of suitable transition timeframes.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As some aspects will require development of systems, processes and policies Specialist Medical Colleges will require flexibility with implementation timeframes.

Q4 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?

The mandatory Professional Development Plan would require significant resources and time to create and implement; a suitable transition time would be required.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

[redacted] is in agreement that a flexible approach to recertification programs is appropriate. Of particular importance is that Specialist Medical Colleges have the flexibility to decide and develop a program appropriate for their professional scope.

Q6 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?

[redacted] agrees with the proposal that each Specialist Medical College provide RPR as an option for doctors within their recertification program, rather than as a mandatory requirement. RPR is an expensive exercise for doctors and is resource intensive. The costs of participating in a RPR may prove to be prohibitive for many doctors.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Yes**

The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

9 November 2018

Carol Parreno
Strategic Project Manager
Medical Council of New Zealand
PO Box 10-509
Wellington 6011

sconsultation@mcnz.org.nz

Tēnā koe Ms Parreno

Towards Strengthening Recertification Requirements for Vocationally-Registered Doctors in New Zealand

Thank you for giving The Royal New Zealand College of General Practitioners (the College) the opportunity to comment on your discussion document, *Towards Strengthening Recertification Requirements for Vocationally-Registered Doctors in New Zealand*. The key points that we wish to make in this submission are that:

- The College is largely supportive of the approach taken.
- The proposed requirement for individual PDPs is likely to be the most significant stumbling block for general practice.
- Audit and peer review have real benefits for general practice. There might be real value in having the Council create an inventory of available tools within the sector, with a view to facilitating the sharing of these resources across accredited recertification providers.
- Health equity expectations need to be embedded within recertification requirements.

Further information in relation to these points is provided below.

Background

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body. The College is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists and sets standards for general practice. The College has a commitment to embed the three principles (participation,

partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population needs for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high-quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Submission

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

The College is generally supportive of the approach taken and that the content outlined in the current consultation document is clear and draws well on the international evidence.

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

The College suggests that the Medical Council of New Zealand (MCNZ) provide clear timeframes and guidance around implementation. The College will need to work closely with MCNZ to ensure that any changes made to our recertification programme aligns to the context of General Practice, our curriculum and takes into consideration the lack of continuing professional development funding GPs receive from the government compared to hospital-based medical practitioners who receive professional development funding as part of being employed by the District Health Boards.

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

Whilst there is value in requiring doctors to keep and maintain a professional development plan (PDP), there are likely to be difficulties in implementing these in general practice. It is worth noting:

- Previous efforts to introduce a PDP requirement in general practice have not worked well, and members have largely viewed the PDP as an after-the-event tick box (compliance) exercise.

- A recent attempt by the Royal Australian College of General Practitioners to introduce a PDP requirement in that country was a failure and has been cancelled. This may colour New Zealand GP's perceptions of PDP.
- A PDP can work well in certain settings; and less well in others. It seems well suited to the District Health Board (DHBs) environment where it can sit alongside the performance appraisal and performance management processes. But the College is concerned that it will be more difficult to implement in general practice where doctors are often self-employed and where performance processes are not well established.

The College suggests that MCNZ considers how to best align a PDP requirement with the practicalities of how general practices are managed. To ensure successful implementation of PDP in general practice, the College would welcome working collaboratively with MCNZ.

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?***

Please see response to question three.

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

The College recommends that a health equity approach is embedded within recertification, which includes:

- Te Tiriti o Waitangi / Treaty of Waitangi training, to understand New Zealand history, including basic understanding of te reo Māori, tikanga Māori and of iwi/hapu in the area where the GP practices. This is particularly important given the number of international medical graduates, who may not have had exposure to Māori language and tikanga previously in their medical careers.
- Health equity, in its broadest sense, to be embedded in every recertification programme to avoid inequities such as institutionalised racism and unconscious bias.
- An expectation that vocationally-registered doctors be culturally competent. It is recommended that MCNZ continue to make cultural competency training in recertification programmes mandatory and engage with Colleges for a cohesive approach.
- The introduction of ethnicity clinical audit tools to assist medical practitioners. Ethnicity audit tools will assist practices, medical practitioners (including GPs) to understand their patient populations, and to monitor and improve clinical and cultural competence and contribute to improving patient outcomes.
- Regular health literacy and communication skills training.

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?***

Audit and peer review programmes have real benefits for general practice when done well. The College view is that audit and peer review programmes have real benefits for general practice. The models in place at Pegasus, and various online audit tools being used or trialled at other PHOs, and at bpac^{nz}, HQSC and via Conporto EDM, are good examples of how technology can positively enable peer review.

These draw on real practice data, evidence from best practice and give GPs an opportunity to reflect on their practice in a supportive way. There is value in creating an inventory of available tools for the membership, with a view to facilitating the sharing of these resources across accredited recertification providers.

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

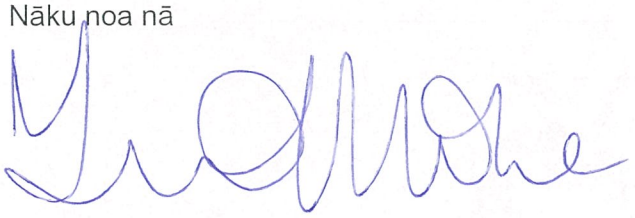
The College suggests that MCNZ provide clear timeframes and guidance around implementation. The College re-accreditation is due 2021, and it will take time for the College to develop and implement new processes that will meet MCNZ expectations outlined in this discussion document.

We are determined to work closely with MCNZ to ensure that changes we make to our recertification programme will meet your expectations.

Our final request is that MCNZ provide clear timeframes and guidance around implementation. We note that the College re-accreditation is due in the next couple of years, and it will take time for the College to develop and implement new processes that will meet the expectations you have outlined.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Nāku noa nā



Ms Terina Moke
Acting Chief Executive

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, September 10, 2018 2:04:49 PM
Last Modified:	Monday, September 10, 2018 2:18:30 PM
Time Spent:	00:13:40

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Somewhat confusing. Needs to be simplified. Surely point 4 would suffice with the addition of education activities

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

It does need to be driven by the profession through the respective Colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes, in its current form it looks clumsy and is not 'encouraging' doctors to participate

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes. Audit.

Q6 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?

RPR is a good concept

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Tidy up the terminology. The document needs to describe the concept and thinking behind PDP. I don't like the term 'strengthening' rather it should be 'improving': a more positive inclusive approach.

Page 2: Submission information

Q8 Your information:

Name	**RICHARD ACLAND**
Company	**ACLAND MEDICAL SERVICES**
Email Address	[redacted]

Q9 Your position/title:

Rehabilitation Medicine Specialist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:58:42 PM
Last Modified: Thursday, September 06, 2018 6:10:20 PM
Time Spent: 00:11:37

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I have some reservations about how a relevance vs a time based approach may work. but also I see a lot of problems in the current system as relates to my area, general practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

as far as PDP, the issue is identifying what you dont know. In a sense the discussion document highlights this, but doesnt given specific pointers to how identify this other than audits- and these only identiffy a tiny area usually- and some sort of practice visits. Those of us as teachers within out Colleges are useed to IPVs and do them, but there is no credentuallation systenm for teachers, and most in GP are volunteers and not adequately or even reimbursed at all. There needs to be professional development of those external auditors and in practice visitors and a system whereby decisions can be contested if there is a breakdown in communication, a little similar to employment issues, labour Dept mediation and then the Employment Court. Bringing it in without these risks major unfairness which will create enormous anxiety among the profession increasing job insecurity and isking flight from practice or even overseas.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I think each College mneeds to develop a clear system of mediation and arbitration for all issues within the College, and only if unresolved, or considered more serious should the Medical Council/ MDC be involved.

Page 2: Submission information

Q8 Your information:

Name	**Jacqueline S Te M Allan**
Company	**Tiakina Te Ora Ltd**
Email Address	**Principal Director**

Q9 Your position/title:

General Practioner.

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 6:16:35 PM
Last Modified:	Thursday, September 06, 2018 6:31:40 PM
Time Spent:	00:15:05

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

the medical council should let the australasian college of each specialty decide on appropriate recertification. this is just more bureaucratic paperwork and time wasting for all specialists who already have too much work on hand.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

let the colleges run the doctors of australasia and the council can supervise events and standards and immigration of overseas doctors

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

you are likely to encounter huge differences in approaches and likely disagreements from the colleges and the worse case scenario is you'd force them to split being australasian and each country. not only that but the added workload to recertify is just a waste of our time and the likely increase in council fees which will follow again is a waste of taxpayers money

Q4 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?

the degree to which you'll have to specifically implement factors and values for each college is ludicrious, let the colleges which is already run by the appropriate specialists maintain the current standards not some board or committee run by political activists, doctors with little experience in subspecialty realms and leave it alone

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

let the current status quo be

Q6 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?

the current status quo is fine

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

i would stop wasting our time with it

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 10:40:21 AM
Last Modified: Friday, September 07, 2018 10:54:25 AM
Time Spent: 00:14:03

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

These should be complementary to our college reaccreditation programs. If the college program covers the required activities then this should be acceptable to the council to avoid unnecessary duplication

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Look at the college program first, allow for endorsement of acceptable programs as opposed to reinventing the wheel

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Main challenge = resistance from clinicians. Re accreditation & maintenance of standards is important, but if you ask clinicians to undergo a separate program to our college one that covers the same ground then there will be inevitable program fatigue & a box ticking mentality may develop. Provided the council system is simple to use & the same activity can be used for both, this could be mitigated.

Q4 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?

Look at the college program, e.g. our anaesthesia program is both rigorous, transparent & regularly audited. If the college program seems acceptable then trust it!

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Maintaining ACLS (or equivalent higher level course - EMAC covers this for anaesthesia)

Q6 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 above, my college has a robust program that already works well. Please trust it

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Work with the colleges, they are generally trying to achieve the same thing, there is no need for the council to add more CPD etc to us if we're already doing this at a college level

Page 2: Submission information

Q8 Your information:

Name	**Cameron Anderson**
Company	**Waikato DHB**
Email Address	[redacted]

Q9 Your position/title:

Specialist Anaesthetist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 11:14:29 PM
Last Modified:	Thursday, September 06, 2018 11:20:18 PM
Time Spent:	00:05:48

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Have never heard of it so no useful ideas

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

See answer 1

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Lack of engagement / communication from NZMC

Q4 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?

Better communication and peer led rather than top down processes

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Peer to peer review organised by our speciality specific professional body

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

See above - engagement and communication

Page 2: Submission information

Q8 Your information:

Name	**Geoff Anderson**
Company	**None**
Email Address	[redacted]

Q9 Your position/title:

Consultant Orthopaedic Surgeon

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:21:07 PM
Last Modified: Thursday, September 06, 2018 5:31:44 PM
Time Spent: 00:10:37

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

ok

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

ok

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. I am an [redacted] in private practice and easily meet all my requirements every year. Not sure how PDP will work - the plan is always best determined with another individual usually a manager. Do I do the PDP by myself or with another colleague? Also patient/client feedback will not work for many [redacted] as many of us undertake medicolegal work and we need to be independent form the client. Unless the client is seen to be the referring Case Manager. Because of the nature of work undertaken, the best [redacted] will not get good feedback from many of the patients seen and trying to get feedback may be seen to influence our independence and impartiality.

Q4 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?

'See answer to 3. Could be done through Colleges, referring organisations for some of us, or from colleagues.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, except maybe the need for audit, peer review and meeting a certain level of CPD activities.

Q6 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 currently undertaken with a group of colleagues. [redacted] is not like any other specialty in NZ.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, September 12, 2018 12:58:35 PM
Last Modified: Wednesday, September 12, 2018 1:03:43 PM
Time Spent: 00:05:08

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I don't see evidence for the need for this

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Less is more

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. Cost and burden on doctors. Opportunity cost - what could these professionals be doing with their time that would be more productive?

Q4 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?

Don't "strengthen" recertification. Stop treating doctors like children.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

None at all

Q6 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?

Everybody does CME. Why change anything at all?

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Just don't do it.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: Bruce Arroll [redacted]
Sent: Monday, 5 November 2018 6:57 p.m.
To: Strategic Consultation
Cc: Bruce Arroll
Subject: Feedback on re- certification

Dear Carol

I have some comments on the discussion document on recertification. I am an older gp and the director of the goodfellow unit at the university of AUCKLAND and a professor in the Department of General Practice.

On page 4 you suggest there be 50 hours per year which I think is reasonable
- the audit needs some exemplars as this is very loose. You could consider a rotating curriculum
- some of the peer review needs to be specified e.g. managing blood pressure , preventing heart disease and stroke.

Doctors practicing over 65 years of age should have a hearing test. We took over the practice of a doctor in his late 70s. All his blood pressures were 130/80 or 120/80. I don't think he was fraudulent and we had to report him to the medical council - a sad way to end a career.

Could you explain multi source feedback. Nurses often know who is good and who is not so they could be a good source.

Our unit does webinars which have the capacity for the audience to ask questions.i think they should be encouraged.

Some traditional CME is ok for getting recertification. If you are going to add reflective practice consider giving examples. Perhaps the college could do a random audit of the written form.

Specify feedback on prescribing data and lab test data (not readily available).

I think a practice review with a colleague sitting in should be required for every 5 years over 60- there is evidence that older doctors know less but they may have more skills.

Sent from my iPhone

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:14:52 PM
Last Modified: Thursday, September 06, 2018 10:14:26 PM
Time Spent: 00:59:34

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

We all have different learning styles approaches and most constructive approaches. I constantly use a range of CME methods and reflective practice is a core in every patient encounter. I find it helpful to have component options suggested but get stifled by needs to write justifications and proofs of what and why I am learing something. The time used to do that distracts from learning and is an added burden in time constrained daily clinical practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't make gthings so prescriptive and rigid that it stifles personal progress. It is after all ending up in more compliance paper work. I have found the current RAZCP programme is trending to stifling when we have to start spelling out justifications for learning

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

In general no. It just adjusts the emphasis of how we think about CME from an updated perspective. However the single biggest challenge is absence of ring fenced time despite the SMO MECA intent that a percentage of time is ring fenced for non-clinical work. The fourth and fifth essential partners in implementing ideal/adequate at the end of the documnet must be DHBs and the highly supportive ASMS. At present CME squeezes into dogends of time when patient DNA or on motivated but unpaid evenings at home. The true value of headroom for good CME and patient centred self development must be strictly supported at the coal face which in turn is compromised by inadequate SMO staffing (in our department).

Q4 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?

The colleges are at liberty to set ideals but SMOs are not always at liberty fulfil these properly for the reasons above. There is a sense of threat for not demonstrating CPD performance when in reality I do far more CME and CPD than I can ever pragmatically record and if I were to do so it would rob time from the learning. I like the ideas of practice reviews - perhaps where an SMO from a neighbouring DHB reviews my practice or vice versa. But again employers will need to endorse and support whatever time is deemed relevant - e.g day release.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review. Listening to feedback whether by survey or through active listening to patients families and non doctor co-workers. These are strongly and naturlly built into a well fuunctiong Multi Professional Patient Centered team such as I see in some quarters of psychiatry. Regretably this is not universal and is current at great threat from service overload eroding best/ideal practice.

Q6 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?

No except the quality of reviewers would need checking and some speciality related framework should be developed. I suggest that in psychiatry it is not that easy to do outside of the over medicalised end of the spectrum

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

1. There is (at recent conferences and elsewhere) a strong push for Patient Centred values based work which I am excited about but have yet to see well embedded in clinical practice. 2. In Mental Health a Multi Professional team approach shares many responsibilties including fro mutual support and shared learning - the patient outcomes should be the product of good team work. I worry that over focus on individual doctors fails to encourage or acknowledge such synergistic outcomes. rather it encourages us to stay in doctors' silos and may encourage isolation and arrogance of ability. I have yet to find a Mental health team that does not appreciate an eaglitarian approach where mutual valuation of role is not welcomed but not often present.

Page 2: Submission information

Q8 Your information:

Name	**Andrew Aston**
Company	**MidCentralDHB**
Email Address	[redacted]

Q9 Your position/title:

Psychiatrist Dr.

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, November 02, 2018 6:52:35 AM
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Time Spent:	00:03:36

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

You need to KEEP IT SIMPLE

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

RELEVACE TO JOB

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

YES IF IT IS TOO COMPLICATED

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME

Q6 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?

CURRENT ONES BUT SURVEYS ARE NOT VLID FOR SOME PARTS OF THE PROFESSION

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Simon Barclay**
Company	**Salcombe consulting**
Email Address	[redacted]

Q9 Your position/title:

Managing Director

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 11:10:04 AM
Last Modified: Wednesday, October 31, 2018 11:17:26 AM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

in agreement

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

incorporated into departmental programmes and appraisals

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

more challenging for small departments / more isolated workers

Q4 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?

need excellent IT portals

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

tricky due to the variety of practice and settings

Q6 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?

not sure - should be workable

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

any considerations for different career stages

Page 2: Submission information

Q8 Your information:

Name	**David Barker**
Company	**Northland DHB**
Email Address	[redacted]

Q9 Your position/title:

Senior Medical Officer

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, November 04, 2018 2:18:32 PM
Last Modified: Sunday, November 04, 2018 2:24:43 PM
Time Spent: 00:06:10

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Artificial creation of these different domains/silos of learning has always been an issue in GP MOPS. Why is there this need to have all these separate but blurry edged categories? Make sure it is doctor centred, we don't have time to go off seeking 3rd party feedback.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

By reducing number of categories - for example Peer Review, General CME and Audit, Cultural Competence and proof of CPR skills. Keep to few categories

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

only if more onerous than currently.

Q4 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?

unsure

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review, CPR and I suppose cultural competency

Q6 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?

Providers may have issues with sufficient staffing to drive any more complex schemes

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Keep it simple

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 08, 2018 8:13:30 AM
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Time Spent: 00:15:35

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Currently the colleges manage these activities. Is there really a need for the MCNZ to duplicate this process. Shouldnt the MCNZ simply oversee and audit the colleges performances?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Use the colleges to impliment.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Issues such as peer review are by their very nature best performed by those working in the same field as the specialist. These craft groups are often small and become a mate-reviewing-mate process. There is no reasonable alternative therefore I seriously doubt the value of peer review i this process. It is largely rubber stamping

Q4 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?

using nominaters reviewers for PRP would entail considerable cost. I dont see this as reasonable considering the other costs associated with practice.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, this should be determined at college level, and at the level of hospitals which should have competency requirements of their specialists, eg CPR, cultural competency etc

Q6 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 per my answer to Q3

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The MCNZ needs to engage with the colleges on this as many already have satisfactory processes in place. The need for evidence based processes has been highlighted. Is there evidence that the status quo needs to change. Do we have evidence that the current mechanisms are broken, or are leading to poor outcomes??

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 1:42:17 PM
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Time Spent:	00:18:20

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Should accept the large amount we do in our usual practice not just require extra activities

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Flexibility about auditing practices that we find clinically useful

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

To much beurocracy . Time use and record keeping

Q4 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?

People like to increase demands to justify their existance.this sounds snarky but is serious. We are very time pressured. How much assesment is really necessary and how much is keeping up with the other colleges etc.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Cpr and peer review

Q6 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?

r. Peer groups work best

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Reducerecording and reporting requirements

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, October 18, 2018 4:32:19 PM
Last Modified:	Thursday, October 18, 2018 4:40:35 PM
Time Spent:	00:08:15

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

its a great document

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

cultural competence for all IMGs

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

convincing all colleges that cultural competence is an important component of recertification, at the moment all colleges and DHBs saw that they are willing to participate but when you actually really look at what the organisations offer its very basic.

Q4 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?

encourage all colleges to follow on from what the new medical graduates are being taught in the medical schools e.g. MIHI in Christchurch has developed a cc course for the College of O&G that is evidence based, and directly related to medical school learning, they courses can be integrated into all specialities and the providers are experts in their field. They would be interested in helping, that way everyone in NZ is doing the same thing for Maori and it is the gold standard of care.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes

Q6 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?

no

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

good luck

Page 2: Submission information

Q8 Your information:

Name	**angela beard**
Company	**COGA**
Email Address	[redacted]

Q9 Your position/title:

Dr

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 8:13:41 PM
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Time Spent: 00:13:51

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Too vague, should be left entirely to appropriate Colleges

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

As above

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Unclear what is being proposed. There are real dangers of discouraging Medical Students from doing General Practice with even more restrictions and regulations for very low income.

Q4 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?

Yes. There has to be more options relevant to practice and fewer PC non-evidence based requirements or tick boxes.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, we are too diverse and already have too many imposed, non-relevant requirements.

Q6 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?

We do peer review well. RPR is over-rated

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Let the Colleges work with their Vocationally registered members only.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, September 11, 2018 12:02:24 AM
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Time Spent:	00:10:12

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

No relevance whatsoever to RMOs per usual MCNZ attitudes

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Stop wasting time on audits and consumers. Focus on patients and our fiduciary relationshop

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

You are out of touch with RMOs. You have no relationship with the many, many hours of real clinical work we do and what this means for our capaciiy to engage with non-college mandated accreditation activities

Q4 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?

Well the colleges are doing OK, but you would seem to have a problem with the very high standards they already set and seem to add to the burden already thrust upon RMOs. Maybe cut us a break. There's a suggestion. Between exams and research requirements, MCNZ adding their two cents seems irrelevant/inflammatory

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

ACLS

Q6 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?

Our college already has them set up. The DHBs have nothing of relevance to contribute.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Stop focussing on GPs.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: Phil Borrie <[redacted]>
Sent: Thursday, 8 November 2018 4:41 p.m.
To: Strategic Consultation
Subject: Strengthening Recertification for Vocationally Registered Doctors
Attachments: SKM_4050181108094800.pdf

Dear Andrew

Thank you for the recent email regarding recertification. I have read the newsletter and strongly support the Council's aims.

I am a Radiologist practising in Tauranga. I have significant concerns that overseas tele-radiologists who are providing services to New Zealand radiology departments do not have to be registered in New Zealand. The College of Radiologists representative had a meeting earlier this year with HPCAA members to raise this concern. Despite a very positive hearing from the Health Select Committee, the HPCAA Amendment Bill did not include a recommendation in its report to require registration of overseas tele-radiologists. (See attached) also reported in NZ Herald 19/09/18.

I believe that registration is required. These radiologists report the same examinations that I am reporting and should comply with the Medical Council requirements expected of me. If an overseas radiologist comes to New Zealand and works in our hospital as a locum, I or one of the other radiologists have to provide oversight, yet if they report from overseas no oversight is required. Some of my colleagues feel quite strongly that if the tele-radiologists do not need to be registered, the same should apply to us.

The newsletter talks about quality, accountability and providing assurance to the public that certain standards are met, and in the above situation there is a mis-match which I believe needs to be addressed. I would be interested in Medical Council's thoughts.

Yours sincerely
Phil Borrie
Radiologist

part of modern health care.

In terms of process and in line with the By-laws of the Faculty of Clinical Radiology, nominations were sought from the membership. Each of the nominees was invited to present their vision and priorities for the role to Faculty Council before Council deliberation and decision regarding the successful applicant. On behalf of the Faculty Council, I would like to convey my thanks to the nominees for the time and energy invested in each of the high-quality presentations.

It is with pleasure that I announce that A/Prof Dinesh Varma has been elected by Council as the inaugural Chief of Professional Practice for a three-year term from 1 January 2019. Dinesh brings a wealth of experience to this role, from both clinical practice and leadership of our College having served as President and Chief Censor in recent years. There are many challenges in the area of professional practice and I am confident that Dinesh will lead the membership in a positive direction.

Professional Practice Committee

If you are interested in contributing to the future of our profession I encourage you to join the Professional Practice Committee (PPC) which is being formed to work with the new Chief of Professional Practice. This Committee will be tasked with facilitating a seamless journey for College members, navigating the transition from trainee to Fellow and managing the development of areas of special interest and sub-specialty practice without adversely impacting upon the capacity of general radiologists to practice.

Further detail about the Professional Practice Committee, including information about the expression of interest process can be found on the College website.

Health Practitioners Competence Assurance Act (HPCAA) Amendment Bill – New Zealand

The College has been advocating for the New Zealand government to change registration requirements so that overseas radiologists providing teleradiology services must be registered in New Zealand. In written and verbal submissions made in April and May of this year to the New Zealand Parliaments Health Select Committee, Dr Lance Lawler, President and Mr Mark Nevin, Senior Executive Officer advocated to have the HPCAA Amendment Bill include a new requirement for registration of overseas practitioners providing telehealth services in New Zealand.

On 17 September, the New Zealand Parliament's Health Select Committee released its report on the Health Practitioners Competence Assurance Act (HPCAA) Amendment Bill. It was very disappointing to see that despite a very positive hearing the Health Select Committee did not include a recommendation in its report to require registration of overseas teleradiologists be added to the Bill. We will continue advocacing to ensure New Zealand patients receive high quality care from doctors that are registered in New Zealand.

Changes to the Health Insurance Act (HIA) – Australia

From 1 July 2018 the Federal Government introduced changes to HIA in relation to the prevention, identification and treatment of incorrect claiming, inappropriate practice and fraud by health care providers and suppliers. The changes cover record keeping requirements, debt recovery mechanisms and importantly from 1 July 2019 a Shared Debt Recovery Scheme will commence which will hold an

[redacted]

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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Learning should be based on an appraisal of professional development needs. Learning and assessment ideally takes place in a practitioners usual place of work.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

There need to be safe systems for collecting evidence of the quality of practice. Some use of quantitative data. Peer review such as regular practice review is key.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Cost and time. But current CPD requirements that allow people to attend an annual conference that in no way meets any identified learning needs is pointless. Learning needs to be intentional. But obviously once a person has Fellowship of a professional college the assessment is formative not summative.

Q4 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?

Cost and human resource required to roll out regular practice review

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Regular practice review - three yearly seems reasonable. It should include the current requirements - a 360, patient survey and practice visit. We are a long way off this but just because it is not the easy thing to do does not mean it is not the right thing to do.

Q6 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?

Covered in previous answers

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Nope

Page 2: Submission information

Q8 Your information:

Name	**Joe Bourne**
Company	**Nga Kakano Foundation**
Email Address	[redacted]

Q9 Your position/title:

General practitioner

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, November 05, 2018 5:05:55 PM
Last Modified:	Monday, November 05, 2018 5:13:44 PM
Time Spent:	00:07:49

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Concerned regarding the increased time required for peer review and 360 assessments

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Our college has already extended the CME programme - now almost unworkable!

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Increasing number of tick box requirements makes it difficult, also the more categories the easier it is to misclassify CME, almost need education on how to fit your CME done into the matrix required

Q4 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?

Onerus audit of compliance

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

ACLS / BLS

Q6 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?

Happy to stay with the college programme

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

HIgh levels of burnout amongst medical staff generally currently - don't need to be further burdened with complexity.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 9:14:16 AM
Last Modified: Wednesday, October 31, 2018 9:24:59 AM
Time Spent: 00:10:43

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The idea that it be more work-based is excellent. I like the components mentioned in the report.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

A "smorgasbord" of choices that are applciable to a specialty or situation would help perhaps with templates for how these might be implemented in similar situations. Eg in paediatrics, a template for reviewign clinci letters or feeding back on a ward round might be sueful.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Getting buy-in and acceptance that this is not just a tick-box exercise. Finding the time to do this in a meaningful way. There is a current view that conferences are a key learning means, and I wonder for many clinicians if that is so, but it's easier to show management that you have been taught at a conference than that you have learnt from spending a half day sitting in on a colleague's clinic.

Q4 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?

"marrying up" the demands of colleges, teh Council, and the employer can be difficult, eg in annual reviews (performance apraisals) when the PDP might be discussed. Our team beleives that that shoudl primarily be a prompt for a formative discussio between the CD/HoD and teh clinician, but documentation is required for several oterh bodies with differing needs.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Having a colleague view one's practicve and provide feedback seems a very good idea even if only for a 1/2 or full day, but there is a cost and a question about who carries that cost.

Q6 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?

See earlier comments. RACP has worked through this in some detail and I've fedback in detail to their working group.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Looks good to me. It will create a burden on the system time-wise and the ongoing need for more time supervising and being supervised remains a challenge in a a stretched work environment.

Page 2: Submission information

Q8 Your information:

Name	**Steve Bradley**
Company	**Lakes DHB**
Email Address	[redacted]

Q9 Your position/title:

Paediatrician, Clinical Director

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 25, 2018 5:55:46 PM
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Time Spent: 00:13:29

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

As a Mum; Ive had to leave medicine to do IVF; and there was no cme I coul do while out of practice. When I came back to work ED was so impossible to do w baby twins I retrained In GP. i regularly do daily CME including guidelines bpac NICE and canadian/ research teviews, fellowship paper sudy via uni Otago, peer group, podcadts; journals, audits and also seeking out clever peers.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

It all steals time off health and kids and I think with over 50 percent of us in GP wanting to limit our hours ... I dont see the new CME requirements in addition ...to what we already do ... in a resource constrained environs where we are being adked to do more and more from secondary care ..eg hep C prescribing; palliative cares, chronic geriatric rounds in rest homes; extended hours and urg care. Further cMe in whose time? Family time.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. We can and will limit our hours and this will further limit access to primary care.

Q4 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?

Ive noted there is no renumeration for the teaching I do and ahain it feels like primary care is devalued by DHBs.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer group is impt. We pay for all our cme in gp and its 12-15k for free at dhb so this disadvatages primary care and does mean those mums at bottom end of pay scale struggle to affor it. Ive friends who are female hps w 3/4/5 kids who struggle to pay for cme.

Q6 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?

Podcasts and free access to jnls. I paid 2k for a paper just to get library articles i cant afford as a gp. I hate that.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I use online foamed and gpcme from canada as it doesnt cost

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Sent: Thursday, 13 September 2018 10:03 p.m.
To: Strategic Consultation
Subject: Recertification Consultation

Categories: Blue Category

Carol Parreno - Strategic Project Manager

Please submit my comments to Dr Connolly and those deliberating on Recertification.

I write as one who has been subject to UK recertification and revalidation for many years prior to my arrival in New Zealand 8 years ago. I still have my long line of red lever arch A4 folders, one for each year - each one full, and representing approximately a weeks work to physically write and collect evidence. Every time I look at them I thank God I am in New Zealand and away from the huge burden that system created and the way it nearly drove me to give up the medicine I love.

To a great extent, the UK led the introduction of the "internationally" developed systems you allude to in the introduction to your document. Lets look if I may at what was actually the underlying premise/driving force that created the UK system. The key driving force for this, was the fall out from Dr Harold Shipman. Shipman was a mass murderer who happened to be a doctor. Politicians led by Tony Blair used the fall out from Shipman to justify driving through an onerous system of appraisal, subtly implying that it would prevent another Shipman. This, as anyone who looked into the Shipman case knew, was rubbish - Shipman was meticulous with his paperwork and would have sailed through appraisal and revalidation, with lots of glowing letters from his patients who loved him up to the point when he killed them.

What was the reality of that system I left 8 years ago (in all probability worse now as with each change it always got more onerous). What were its good and bad points?

Good

- IF you had a good appraisor, it gave you about 3 hours each year to reflect together on your practice, your folder of evidence and your medical goals. With a wise and thoughtful GP colleague, who saw his or her role primarily to encourage a fellow colleague to new achieve greater excellence in their work - this could be very constructive.

Bad

- If you had a bad auditor/headmaster minded GP, hell bent on finding and expelling miscreant doctors, it could be highly threatening destructive process which threatened you, your livelihood and at times your health.
- Almost all of the 40-50 hours spent creating the folder was frankly depressing. When I read through the folders, most of it was useless waffle, created to appease the system. It did not change my practice, except to depress me, and make me start preparations to leave medicine and take up finance, simply to put bread on the table for my family.
- Endless naval gazing - yes we need to be reflective, but not to the extent of writing an A4 page of reflection on every CME event, significant event, inspection - the list goes on and on - endlessly writing down what you will do to improve - most of it you made up as you were forced to write something. When you have done it 50 times, you cant hope to remember, let alone implement your ideas.

- All the things that really matter to me as a GP - spending that extra time with a grieving patient, making doubly sure you get a patient seen urgently when you fear they have sinister pathology, taking time to explain a patients illness to them - all are completely and utterly ignored in the process. Instead, you are largely judged by what auditors can measure.
- It still had the overtone (whatever shine was put on it) of you as a doctor proving your self each time, and at a base level, proving you were not another Shipman.
- The end result for me and every British doctor I have met in NZ who has left UK to come to NZ in the last 8 years, was that this system contributed significantly to driving us out of UK in a search for somewhere to be allowed to care for the patients we loved; somewhere we were not going to pay for the privilege of continuing to work at the cost of our own health.

I write all this to ask you NOT to assume that the motherland knows better, which has been a constant feeling I have got from Kiwis in the last 8 years. The system in UK is broken, badly broken - the NHS only survives because until recently (Brexit is already changing this) it had an endless supply of EU doctors to fill the places I and others vacated, having been driven to emigrate/early retirement. New Zealand does not have the same luxury, and anyway, do we want to treat our most important medical resource in the same way?

You have undoubtedly the best General Practice work environment in the world. That environment is what makes us GPs feel good about going to work each day, if you love your job and find your workplace a good environment to work in, it goes a long way to you working hard for your patients. **Please dont put this at risk**. There is this overwhelming sense in your document that doctors need more regulation - exactly the same feeling in UK 20 years ago - look where it ended up. Politicians drove the changes to make them look good and grab votes, dont sacrifice doctors on the same altar. Having worked with many GPs in NZ and seen the work of dozens of hospital doctors in NZ on my patients, I dont see more errors made by NZ doctors due to lighter regulation - in fact I see less. I dont find patients unhappy with the care of my hospital colleagues, I find them effusive in their praise. Doctors are largely happy in their work and when they are happy they work well. Please dont change this.

If you feel you have to change the system, may I make the following suggestions with regard to recertification:-

Do include time - at any appraisal meeting for doctors to sit down with a wise colleague and go through not just the paperwork in the folder, their audits etc but create time for them to talk in confidence and off the record about how work is affecting them, what their struggles are in medicine, the practice/hospital, PHO/DHB, with someone who has been through the same or similar struggles. Medicine is a very lonely business, you have here a **golden opportunity to support all the good doctors and increase our longevity,** I suggest equally as important - if not more so, for the overall well being of patients, rather than simply weed out the bad ones which appears to be the underlying premise of what you are doing. Well adjusted doctors who feel supported, I suggest, will make less mistakes and give more years of good service rather than look to retire early.

Appraisers - just like school inspectors, it tends to attract those who want to inspect. Choose carefully who you appoint. They MUST be all doctors - lay people cant understand the pressures we work under and how easy it is for events on occasions to all align and end up evolving into a bad outcome. Ensure they want to spur colleagues on while at the same time weeding out those who are clearly dangerous.

Dont create a system of endless reflection - you end up just cutting and pasting from 5 years ago and you end up despising the whole process.

Dont allow it to become a tool medical managers can use to subtly threaten and coerce doctors to follow their political/DHB/PHO agendas for fear of failing their appraisal.

360 degree feedback - if you work in a practice with nice doctors you will get nice comments. If you work in a dysfunctional bitchy practice where half the doctors dont speak to the other half - you get nasty comments - just human nature. It is of limited value.

Dont give patient advocate groups too much say in the process. Medicine is not a commodity or commercial enterprise where a large corporate needs to be coerced by consumer groups to get the best deal out of them and stop them charging too much to give fat profits to share holders. Ultimately in UK we created totally unrealistic expectations of what should be the norm and everybody looses. It created an atmosphere where patients never felt they got what they were "entitled to" and doctors felt that they are blamed for less than the perfect outcome which every consumer deserves! If we gave patients what they want at every turn we would end up with a very warped situation where Duromine, Oxynorm and other undesirable things were available at will. It is a caring profession which by and large attracts altruistic vocation orientated people to do its work - they dont respond well to finding at every turn their best efforts are "not enough".

In Summary.

- The Kiwi medical system is a uniquely positive environment to work in, (a reflection of Kiwis themselves), who are some of the most special people in the world. Happy doctors work well, have time to care and wont retire prematurely.
- Dont be lemmings and follow Brits headlong over the precipice into the abyss of a British style appraisal and recertification system, created in a post Shipman era with all the attendant negativity of that time that was woven into it. Ask those who suffered under the UK system what it is like before you copy any aspect, and dont listen to the UK RCGP spin doctors.
- If you have to make changes, create a truly Kiwi system - use this opportunity to create time for a confidential supportive process as well as checking we are good enough - maybe even do it in two parts with 2 different doctors, part A - making sure we are up to standard, part B confidential support and encouragement.
- Dont allow it to be hijacked by pressure from politicians/MOH/consumer groups - true medical care is not a commodity or something to use to create positive sound bites for politicians.

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, September 09, 2018 4:03:38 PM
Last Modified: Sunday, September 09, 2018 4:10:59 PM
Time Spent: 00:07:21

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Concerned that this will become yet another administrative burdon for clinicians without much evidence to support that it will improve outcomes for patients.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Would suggest not going overboard and introduce something that becomes as ardeous as the 'revalidation' process that GMC introduced in the UK. Many GP's left the profession rather than proceed with this programme.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Takes focus away from excisting areas of professional development. There are quite a number of paper based exercises that do not add value and this risks becoming one of those.

Q4 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?

There is a tendency for such programmes to 'grow arms and legs' and become quite ardeous. You need only look at the RNZCGP Cornerstone programme for an example.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

None in addition to what is already required.

Q6 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?

Current peer review programme for GP's is working well. Would not wish to change this.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I would suggest rethinking whether this is required. What problem are you trying to fix and what is the evidence that this avenue will take you down the right path. Watch out for unintended consequenses such as doctors retiring early as a result.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 12:09:00 PM
Last Modified:	Wednesday, October 31, 2018 12:15:38 PM
Time Spent:	00:06:38

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I like the present system why change?! Who is driving this?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Present system is fine I am hugely concerned that recertification will become a business and some practice visits I have seen are totally useless

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As a GP locum practice visits etc would be prohibitive and costly a lot of gps in my position would simply stop working!

Q4 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?

Keep the system similar to now! NO more red tape

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME peer group and audits similar to now

Q6 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?

Costly and difficult to organise for Locums Skype peer groups may work.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don’t change it!

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 7:10:51 PM
Last Modified: Thursday, September 06, 2018 7:15:50 PM
Time Spent: 00:04:59

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am happy with the present system and would not support any change

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

these changes look costly both in time involved and fees etc

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

a lot of GPs would stop working I certainly would think about it(especially older ones) if system is more onerous

Q4 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?

keep things simple like Australia!

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

nothing that isn't covered already

Q6 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 above any increased commitments will see an exodus of older GPs

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I would not support any major changes to the present system

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 8:05:59 PM
Last Modified: Thursday, September 06, 2018 8:14:17 PM
Time Spent: 00:08:18

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

too generic

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

they should be specialty specific

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes, a blanket approach will be detrimental as already evident from the UK system experience

Q4 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?

yes, they should be further delegated to specialists associations

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

they should be established by the single specialties/disciplines

Q6 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?

specialty-based

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

avoid blanket approach, even at college level

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:53:08 PM
Last Modified: Thursday, September 06, 2018 6:06:59 PM
Time Spent: 00:13:50

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

PDP is a waste of my time. Brief quick surveys of things like prescribing are much more usefull than full audit which is cumbersome and time consuming. GPs need to look at MANY things each year not just one

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Scrap PDP for GPs. Surveys as above but data etc collected by someone else -- I DONT HAVE THE TIME OR THE SKILLS TO COLLECT DATA FROM THE SYSTEM

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Looks VERY time consuming -- Who is going to pay for the time / we should not be expected to take time out of family and personal rest to do this

Q4 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?

Do they have the resources????

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Local peer review works best -- small groups

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Charles Carney**
Company	**The Doctors Waipawa**
Email Address	[redacted]

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:15:59 AM
Last Modified: Friday, September 07, 2018 9:32:55 AM
Time Spent: 00:16:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Ok, more of what has gone before.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

As always , keeping track of hours done , audits completed etc

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Most of medicine is art , about 90 percent , it isn't easy to measure , the problem is you end up measuring the tick box stuff that is easy to measure

Q4 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?

Always time and money constraints

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

The best thing is , and the most expensive is to have a colleague sit in and watch you work . Half a day of another doc watching you do the job every couple of years would be much better than ticking a thousand boxes.

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Trial it and get some feed back. I think these things need to evolve gradually. Most docs are already overloaded. They need it to be clear, doable, straightforward. I think the feedback has not been very good in the past ending up in time wasting exercises. Being done which do nothing but tick another box.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, November 05, 2018 3:07:00 PM
Last Modified: Monday, November 05, 2018 3:34:14 PM
Time Spent: 00:27:13

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They are comprehensive, which should be welcomed

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Expected type and volume of each component clearly detailed as in current processes

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Cultural competence may be difficult to achieve without specific training.

Q4 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?

Allowing for individual learning/ improvement needs within their programmes.Solution could include giving individuals greater autonomy in choosing activities

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Maintaing knowledge base relevant to discipline.Communication skills & cultural competence

Q6 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?

Unsure

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Early dissemination of information before changes implemented.Scope for review of changes/feedback after implementation

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 7:14:01 PM
Last Modified:	Thursday, September 06, 2018 7:33:10 PM
Time Spent:	00:19:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I liked the specialty led approach

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

There looks like more emphasis on the PDP - many doctors struggle with writing their PDPs - any improvements to make it less onerous would be welcomed.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Challenge only if the changes are too drastic

Q4 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?

none that I can see at the moment

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer Groups. The 360' multidisciplinary review is a good tool I think

Q6 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?

Self run Peer groups work best. RPR should not be a repeat or rehash of a quality assurance programme eg in general practice the Cornerstone process which has been onerous and an overwhelming TICK BOX exercise.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Show us what exactly this strengthened approach is and ask for feedback. I think the GP college recertification programme is going well - we have just got use to it so would be disappointed if there are too drastic changes to it.

Page 2: Submission information

Q8 Your information:

Name	**Adrienne Chin**
Company	**Doctors on Riccarton**
Email Address	[redacted]

Q9 Your position/title:

General practitoner, practice owner

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, September 19, 2018 6:30:35 PM
Last Modified:	Wednesday, September 19, 2018 7:04:33 PM
Time Spent:	00:33:58

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Lot of paperwork for little gain or no gain.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

PDP is not relevant when I know what I need to keep with each year and month. If every doctor reads the journals he or she should, this covers PDP.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Lots of unnecessary work!

Q4 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?

Who is going to pay for the extra work? At this rate, we are going to be spending so much more time on this paperwork, we will end up seeing less patients.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Yes, there are only 50 practising specialists in my specialty, and we are being pressed hard to cope with clinical work.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't change.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 2:09:36 PM
Last Modified: Wednesday, September 26, 2018 9:48:42 AM
Time Spent: Over a week

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Seem reasonable

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

None

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Current framework seems ok for most

Q4 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?

None

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

What we currently have seems acceptable

Q6 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?

RPR though infrequent, can be disruptive for a practice

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, October 19, 2018 2:42:40 PM
Last Modified: Friday, October 19, 2018 2:52:49 PM
Time Spent: 00:10:08

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Seems sensible - flexibility is essential.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Patient notes audit needs to be simplified.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As long as its kept succinct - it has been getting increasingly cumbersome lately.

Q4 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?

See above

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Cultural awareness. CPR skills. Patient Rights, Health worker rights.

Q6 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?

We need to be able to allow practice meetings and significant events meetings to be counted as peer review.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

KEEP IT SIMPLE!!!

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:38:49 PM
Last Modified: Thursday, September 06, 2018 7:51:15 PM
Time Spent: 01:12:26

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Evidence was not provided regarding how the recertification system produces better safety outcomes than the current CDP system. It was suggested that CPD attendance alone cannot prove good practice which is true, but the proposed system is not capable of adequately controlling a clinicians practice; moreover despite recertification/revalidation schemes being introduced in numerous countries, evidence of improved outcomes is weak and unconvincing. I think it is important to take worldwide leadership in researching what protective factors already exist within medicine (eg, professionalism, institutionalisation of attitudes throughout the training process, self-selection of candidates with certain attitudinal attributes (eg perfectionism, fear of failure, desire for social recognition of intellectual prowess, shame reaction to incompetency), and the protective aspects of working in departments and practices around other conscientious pro-patient professionals. This would be world-leading in terms of understanding and validating the profession, and from this platform it would be possible to design an actual evidence-based approach to assessing doctor's trustworthiness, rather than instituting onerous unproven administrative burdens on clinicians who are already working their hardest. It could be that research would find that complex and subtle personality/attitudinal testing is best correlated with patient safety. I experienced the introduction of revalidation by the GMC in the UK, being a UK trained doctor. The forms and tick-boxes approach would be easy for an intelligent but dangerous doctor such as Harold Shipman to navigate. The greatest danger to patients is a doctor with a poor attitude, and to my experience in 8 hospitals and 12 general practices and 3 universities, that is rare to find; there are easier ways to earn well and be a psychopath than see patients all day.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think high quality research into attitudinal and professional attributes of the profession as a whole and individual doctors should be invested in and carried out. I secondly think departments and general practices should be held accountable for their clinicians CPD and performance via internal review. This way, instead of the recertification administration and time burden falling on the individual doctor eating into their already limited personal life, the required CDP would become part of departmental life and the department would be motivated to provide in-house learning (research would show that this already happens in most departments, and colleagues get a very clear impression of the competence of their peers).

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I think care must be taken to not alienate people who are already trying their hardest. Conveying the message of 'we're not sure you're trying hard enough' is damaging to clinician morale. Protecting the perks of the job is important because dealing with bodily fluids, emotionally distressed people, high intra and interpersonal stress and performance requirements add up to make medicine a taxing but rewarding job. Clinicians are well paid due to the high requirements and personal costs of the job. To continue attracting the top, most intelligent candidates and increasing the functioning of current clinicians, careful attention and research should be made into creating a positive work environment, where supported clinicians pass on the benefits to their staff and patients. Put pressure on already stressed people and you risk losing the respect of a group of generally decent-hearted, hard-working and high performing individuals. The goal is patient well-being. Observe the current health outcomes of the NHS in recent years compared to earlier years to see the effect that heavy handed regulation, negative clinician morale and public undermining of clinicians intentions, work and worth by politicians does for patient care.

Q4 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?

Implementation of recertification programmes will cost the Medical Council millions, and likely increase costs for college memberships, which will inevitably be covered by doctors or DHBs, thus costing the health service and tax payer ultimately. This will take budget away from where it is most needed: our patients. I think the proposed model, lacking evidence as it does, is ill-conceived although well meant. Put council money into research of the medical profession and professional attitudes, instead of this evidence-lacking international approach.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I think departmental mortality and morbidity audit is essential, and root-cause analysis should be performed of individuals and systems involved. This is in my experience an effective way to identify areas of failure, and potential knowledge gaps in clinicians. Then the department should take care of performance managing the clinician or improving the faulty system. Shame and loss of face have a very strong controlling effect on all but the sociopathic and narcissistic clinicians, but refusal to change should be picked up in the performance management process, and concerns can be escalated to the Medical Council accordingly.

Q6 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?

It's worth analysing what already exists within departments and analysing the extent that those existing processes control the learning and performance behaviour of clinicians. Eg, there exist MDMs where clinicians are publicly asked their opinions on patient management; journal clubs require clinicians to report on recent relevant journal articles. All departments have a patient complaint process. Intra departmental audit, quality assurance programmes and yearly review processes often already exist and are mandatory, and because they are governed by need, they tend to be relevant to practice.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I would strongly advise the Council to reconsider implementing the recertification process, and observe the effect it has had on the medical profession of other nations. Let NZ lead the way in implementing well-researched professional regulation, not knee-jerk copying of other medical councils.

Q8 Your information:

Name	**Esther Coats**
Company	**Auckland DHB**
Email Address	[redacted]

Q9 Your position/title:

Histopathology Registrar (former GP)

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Friday, 12 October 2018 4:58 p.m.
To: Strategic Consultation
Subject: Strengthening recertification for vocationally-registered doctors in New Zealand

Categories: Blue Category

Dear Medical Council of New Zealand,

I would like to make the following submission regarding the proposal for strengthening recertification.

I do not believe we have sufficient evidence to recommend any particular changes to the current system. I disagree with the statement in the document that "New initiatives or innovations, by their very nature, will not be evidence-based". Why is this? We would not accept Pharmac paying for a drug without demonstrated efficacy. The systematic reviews provided in the evidence document show a woefully inadequate evidence base. For example, there was only one randomised trial in the Miller et al BMJ 2010 article – this randomised participants either to multisource feedback with tailored coaching sessions or to standard feedback alone, meaning (as the authors of the systematic review point out) that the effect attributed to MSF may just as easily have been due to tailored coaching sessions. The Cochrane review cited in support of audit did not include any randomised controlled trials (only cluster randomisation) and the effect was widely varying across different studies ("ranges from little or no effect to a substantial effect"). Most importantly, as you note, assessment of the most important outcome, patient outcomes, was very limited.

In addition to the cost in terms of both time and money, MCNZ's proposal has the ability to harm patient health in New Zealand. For example, revalidation in England and Wales has led to a reduction in morale (see for example https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0489-9), and to a reduction in doctors working in the NHS, for example through early retirement (see for example http://futurehospital.rcpjournal.org/content/5/3/192.full), with a subsequent reduction in access to healthcare. Despite this, the system has been proven not to detect highly negligent practitioners (https://www.bmj.com/content/357/bmj.j2583). Although the MCNZ proposal is different to revalidation in the NHS, I mention this as a potential adverse effect of change, however unintended it may be.

How best to improve patient care and even how best to assess it is not obvious - easily obtained measures with high face validity such as high patient satisfaction on survey can be associated with adverse outcomes such as increased mortality (Arch Intern Med. 2012;172(5):405-411).These gaps in our knowledge can only be addressed through well designed randomised trials. These should not be ignored simply because they are hard or expensive to perform - the costs and risks of any proposed changes to recertification will be borne by doctors and district health boards, but ultimately by the population at large.

Yours sincerely,

[redacted]

[redacted]

From: Jeremy Cooper [redacted]
Sent: Thursday, 6 September 2018 8:55 p.m.
To: Strategic Consultation
Subject: about recertification

Categories: Blue Category

Dear MCNZ

I have worked in the USA and in NZ. My MCNZ number is [redacted]

I know Ron Maier who is a recent President of the American College of Surgeons.

He told me they are moving away from recertification exams as a way of keeping people competent. The reason was that as specialists sub specialize they lose their knowledge base and fail to update their knowledge base in areas apart from their narrow subspecialty. Thus a general surgeon could work in the endocrine area exclusively and not be up to date in say cancer , or bowel surgery, or pediatric general surgery after a period of 10 yrs . To devise a "passable" recertification exam for general surgery means that they will have to "dumb down" the exam otherwise they will end up failing everyone.

Thus I think the MCNZ approach is far better and they should strongly resist the idea at every stage of formal re-examination.

Regards

Jeremy Cooper. FANZCA.

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 12:59:03 PM
Last Modified: Friday, September 07, 2018 1:11:09 PM
Time Spent: 00:12:05

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Generally ok

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Please just if whole process can be more streamlined. I find uploading to the dashboard tediously clunky.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As a long-term VR locum direct clinic associated requurements may be difficult.

Q4 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?

Unsure

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer

Q6 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?

I really have enjoyed College remotely organised peer groups given my situation as locum...am not always available to get to local face to face group due to my variable weekly work commitments..

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 1:05:12 PM
Last Modified: Friday, September 07, 2018 1:21:16 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I approve of the idea that the recertification needs to be based in real life - relkevnat to where the docotr or currently practising.. I agree that ticking off attendenace at CME does nothign to ensure competence . In any case if we are doign a dssumative assessment then perhaps we do a 'test of knowledge" but if we are wanting to ensure safe and good practicel work then it is about checkign that the doctor is practingin a learnign way - so looking at how they receive feedback; how they chose what CME to undertake, what they do in pracgtice to ensure that patietnews are safely cared for (whcih relates to the cornerstone accreditation in part) Find out where they turn to for advice - so peer group is important.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

this is tricky when you look at the profession as a whole. I thn that focus oon the solo practitioner is importatn as this is where most 'deviation form the norm" is likely to occur. I thik askign docotrs to visit another praictce as observcer is a really helpful exercise for the person who observes - one sees other ways of doing things. self directed audit I think is important - but it does not need to be the formal externally planned audits - it can be one you do for your own benefit within practice. Inh our practice we have annula performace aprasial by a senior colleague I think it works well. If the couns=cil comes up with a differnect d=structure form the one i developed for our practice use, then I would incorporate it into our appraisal process. .

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No process will reliably pick up the 'struggling" doctors but will pick up the oes who already are failing to provoide good care. I dontl know what can be done to encourage the struggling ones to lift their game especailly if they are in denial. None of us like to think we are in the "lower achieving" side and we persuagde oue=rselves we are doing fine. In my experience and literature search the best measure of a competent doctor is the doctors peers - but it is very hard to feedback to a peer directly. or even indirectly unless they are open to this. . ;l

Q4 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?

for GP the problem is that not all doctors in primary care are aligned with the college.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CPR is achaic now and should not be mandatory in my opinion. I thinh a portfolio approrach is the best option where the doctor has to provde some evidence and reasons why they have done certain activities in the year. The MOPS for GP is currenlty not too bad - a little clunky in that you can "pass" by attending lots of trainign events but some of the best doctors learn best by self learning approaches and these are harder to prove.

Q6 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?

I am not convinced that RPR is necessary espoecially in a group practice environment. I think requiring all docotrs to be the visotr if they work in a solopractice whpouod be a better option. One wants the doctor to see other ways of working which they can learn from .

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:26:07 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

nil

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

none

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

don't know

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes

Q6 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?

good ones,yes

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

Mr Andrew Connolly

22 November 2018

Chairman

Medical Council of New Zealand

MCNZ document(s) "Strengthening recertification for vocationally-registered doctors" 2018

Dear Mr Connolly,

Thank you for the invitation to provide feedback on the proposed restructuring and strengthening of recertification standards. Unfortunately, I now see that the time-frame for submissions has closed (31 October).

As a clinical cardiologist, working in the public system for over four decades and now in part-time private practice, I would like to offer some comments regarding this matter.

I presume that the MCNZ has the following main reference points on which to assess the competency of (vocationally-registered) doctors:

(a) experience from its disciplinary processes, (b) HDC Code of Consumers' Rights, (c) input from NZMA and the Royal Colleges, (d) limited and somewhat contradictory and guarded literature on assessment, (e) international practice, such as from the UK GMC and (f) the social and political environment.

The previous document "Vision and Principles for Recertification" (MCNZ 16 Nov 2016) indicated that feedback on performance will be included. This is again confirmed by the third pillar of the picture on page 4 of the more recent document (MCNZ 2018), stating "informed by public input and referenced to the Code of Consumer's (*sic*) Rights". Feedback is also a component of the UK GMC appraisal and revalidation website, where feedback from both colleagues and patients is mandatory. However, the literature that the MCNZ provided on this subject is cautionary. Miller A and Archer J (MCNZ reference #11**)** cast doubt on its effectiveness in some groups with regard to changes in attitudes, knowledge and benefits to patients. [1] In my experience with the RACP CPD programme, no solicited direct feedback is necessary to obtain the required points. This raises questions on how employers, colleagues or patients will develop programmes to facilitate direct feedback, also the intention of the exercise, and what benefits might accrue to both doctors and the outcomes of patient care. The resources required for this type of activity, involving colleagues, patients and employers (with additional administrative support), would be considerable. I would personally feel comfortable for my correspondence to general practitioners, specialists and patients to be subject for review by colleagues who have my trust to undertake this. Yet, who would have the time, training and energy, if this is an example of what is being proposed? I think it is incumbent on the MCNZ to be more specific about these matters since the MCNZ would drive this change in CPD formats. It is also important that programmes such as these do not undermine doctors' confidence or satisfaction in practising medicine at the coal-face – i.e. the effect of unintended consequences. If it is proposed that a 360^0 feedback system is to be introduced, or a variation of this, then there is the potential threat of negative and/or discouraging comments based on impressions or hearsay, whereas facilitated positive feedback could also be problematic. How would employers select the patients for the survey, for instance, and what questions would be included? Would confidentiality be ensured? Professional recertification should not burden most individual doctors with excessive or unreasonable demands, or potentially damaging consequences.

Of the 19 references that were provided, only 6 were published from 2012 onwards (and I can only access MCNZ #19 in abstract form). This does not seem a satisfactory evidence-base for introducing new changes to the CPD format, in my view. It is my impression from these and other publications that the subject matter

reflects rather weak evidence for best practice, and that there is still much to learn about the mechanisms on whether (or if) these lead to improved patient outcomes in a broad context.

Bloom BS (MCNZ reference #9) reviewed 26 peer-reviewed published meta-analyses or other systematic reviews from studies over a 20-year period to 2004, although only 46% were randomised controlled trials. Eight forms of education methods were tested and he concluded that the most effective techniques were interactive programmes between 'practitioners and educators' – (a) audit and feedback on optimal versus actual care provided (b) diagnosis-specific care reminders for best care (c) academic detailing - where academic staff talk to prescribers (d) clinical practice guidelines and (e) opinion leaders. Some of these also had an effect on patient outcomes, including the adoption or rejection of practises of greater or lesser effectiveness. [2] The tables provided in paragraph 14 have been modified from Bloom's paper and the conclusions differ in respects from Bloom's.

Two articles describe the aims of CPD as a set of hierarchical transitional values, but where current CPD/CME objectives reach only half-way towards the 'summit' of improved behaviour, performance, or benefits to patient and community health. [1,3] Therefore, CPD programmes may be well intended but it is unsatisfactory to merely assume certain objectives without good evidence. Every health professional is fully aware that there are many other non-CPD/CME factors that individual doctors and the medical community have little or no control over, and yet must be integrated into effective health outcomes. The eradication of acute rheumatic fever is one of many such examples where, for instance, adequate housing, poverty and community education must be concurrently addressed. A recent Lancet study indicated that NZ is lagging behind Australia in a number of important health measures (e.g. treatment for certain defined forms of cancer, ischaemic heart disease and others), but I do not imagine that the performance or skills of individual specialists are the predominant cause. [4]

Assimilation of evidence-based medical knowledge in a doctor's field of specialisation is clearly a high priority in CPD, as is effective communication, enquiry, teaching and the maintenance of trust with colleagues, patients and the public. "Society cedes to the medical profession the privilege of self-regulation based on three assumptions: the assumption of expertise, altruism and self-scrutiny". [5] However, there is controversy whether recertification programmes are, in fact, influential in overall clinical care. Regulatory reform of the CME system in the USA and elsewhere is being actively debated regarding this issue, recognising that new criteria for recertification may not improve medical practice or patient outcomes. The relevant literature on this matter is evolving, but not yet conclusive. [5,6,7,8,9,10]

Published guidelines are an important tool to maintain professional standards but demand much research and input from (often) large expert committees, as well as frequent updates. There may be insufficient expert resource available in NZ to provide specialist guidelines for best clinical practice. Although guidelines are relatively limited in focus, and may not account for the complexities of different clinical situations, they are a touchstone for accepted practice. Any deviation would normally require justification. I do not think it is credible that the MCNZ document can dismiss these as having little effect. Most dependable cardiology guidelines originate from the USA and Europe and are frequently referred to in overseas teaching conferences.

In my experience in hospital practice, which is a research and teaching environment, there is often much discussion (and debate) between colleagues on clinical matters. Standards are generally kept at a high-level owing to the inclusive knowledge and experience of the group, and where up-to-date guidelines are an important component. However, it must be admitted that, in isolated practice, additional opportunities for educational needs (with DHB or employer support) might well be desirable. These could take the form of regular mini-sabbaticals, supported access to medical on-line journals, and occasional visits from representatives of the colleges and special societies for case-based discussions focussed on patient care. These activities would likely add considerable value in maintaining an enquiring mind and safe practice. The MCNZ might well encourage and regulate DHBs (and group practices) in their support of professional development of specialists, especially in remote and/or low-decile areas.

In this era of technological dependency, it is also my view that the medical schools and colleges should be more proactive in their insistence that trainees, both in general and specialty programmes, have a higher level

of competency in history taking, examination skills and hand-overs. Trainees need to gain confidence in their own diagnostic and problem-solving abilities, facilitating the appropriate selection of investigations and in moderating their results. These basic attributes, including documentation and correspondence, are not adequately supervised within the DHB environment, in my view, and I believe this probably reflects the disruption generated by frequent roster shifts, chronic under-staffing of senior specialists and the increasing 'efficiencies' of in-hospital care. The MCNZ may be aloof to these matters, yet may have much to offer in the oversight of these core benchmarks of professional training, in conjunction with the professional bodies.

With kind regards,

References:

!. Miller A, Archer J. Impact of workplace-based assessment on doctors' education and performance: a systematic review. BMJ 2010;341:c5064

2. Bloom BS. Effects of continuing medical education on improving physician clinical care and patient health: a review of systematic reviews. Int J Technol Assess Health Care 2005;21(3):380-5

3. Stevenson R, Moore DE. Ascent to the summit of the CME pyramid. JAMA 2018; 319(6):543-4

4. GBD 2015 Healthcare Access and Quality Collaborators. Lancet 2017;390(issue 10091):231-66

5. Johnson DH. Maintenance of certification and Texas SB 1148. A threat to professional self-regulation. JAMA 2017;318(8):697-8

6. Correspondence (Cardenas CJ, Freeman BD, reply Johnson DH). Self-regulation of the medical profession and MOC. JAMA 2018; 319(1):83-85

7. Holmboe ES, Cook DA. Reply: American Board of Internal Medicine and MOC standards. JAMA Internal Medicine 2015; 175(8): 1425

8. Nisssen SE. Reforming the CME system. JAMA 2015;313(18):1813-4

9. Teirstein PS. Boarded to death – why MOC is bad for doctors and patients. N Engl J Med 2015;372(2):106-8

10. Thistlethwaite J, Charlton R, Coomber J. Revalidation for relicensing. Reflections on the proposed British model. Australian Family Physician 2012; 41(12);70-2

[redacted]

From: Spencer Craft [redacted]
Sent: Wednesday, 3 October 2018 12:20 a.m.
To: Strategic Consultation
Subject: recertification

Categories: Blue Category

Dear Colleagues,

After working in Australia for 3.5 years fulltime and some occasional work back in New Zealand, I am now back here fulltime.

During this time NZMC was able to accept my reaccreditation from the RACGP. Much of their accreditation revolved around online lectures & post-lecture testing in combination with conferences. As a Doctor working solo, this was a great way to have my choice of lifelong learning acknowledged. Every year my CME learning was much greater than required.

Both the RACGP & RNZCGP will accept & swap over fellowships when moving from either country.

These Medical Colleges are the only colleges that are not joint Australasian colleges.

On arrival back in New Zealand, I have been forced to join the RNZCGP and follow their much more rigid approach to learning ie. 6 designated sections of learning with the inability to spend more time on different areas.

For example, I do an enormous amount of independent reading on Medical topics [I have read 6-8 medical books from Researchers over the last 18 months]. Most of this cannot be credited because the amount of time spent goes way over the designated points of a single section.

As a locum, I find it very difficult to do Practice surveys & attend peer reviews. A lot of practices have in-house peer reviews, I end up doing a lot of evening Urgentcare work and am not able to get to evening CMEs. I do not have a practice in which to do a survey.

I believe Doctors need greater flexibility in their CME and not be dictated to by academics who are not working at the coal face full time.

I have heard that many many other doctors not working in a single practice struggle with the requirements.

CME needs to be simple to complete. Virtually all doctors continue to read & update themselves every day/week with regards to cases by researching illnesses that are unusual [Dermnet, Health Department, Drug data sheets], reports from Specialists/ pathologists with new diagnoses. Rigidity around what we can do is frustrating as we try to find ways to meet RNZCGP requirements that have no relevance to my work or even stimulate my interest. CME should be self-directed as it always has been. Enthusiasm drives learning not authoritarian rules.

I strongly disagree with being forced to join the RNZCGP just because I now work > 50% of my time in NZ.

As both colleges will automatically accept each other's fellowships AND each Medical Council accepts the other country's College CME, I believe strongly a GP should have the democratic choice of which College/ CME program to join.

I hope the Medical Council can see fit to introduce democratic choice into which CME program I can use or at least allow more flexible learning than what RNZCGP dictates to me.

Yours faithfully,

Dr Spencer Craft; Locum GP, GP Skin Cancer

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 10:24:35 AM
Last Modified:	Wednesday, October 31, 2018 10:38:18 AM
Time Spent:	00:13:43

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

These components seem reasonable and are not unlike our present College CPD

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Goals for individuals could be agreed at Annual Performance review with suggestions for audit being supported and time available in non clinical time.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

PD can get squeezed out. Scheduled times and reminders would be helpful

Q4 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?

Our College system is improving but data entry has been clumsy and time consuming when time often not available.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review groups and some multi source feedback.

Q6 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?

Our current peer review groups work well.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Employer support would be helpful. This would be useful around audit and multisource feedback.

Page 2: Submission information

Q8 Your information:

Name	**Brian**
Company	**Craig**
Email Address	[redacted]

Q9 Your position/title:

Consultant Psychiatrist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, November 02, 2018 11:53:51 AM
Last Modified:	Friday, November 02, 2018 12:21:53 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Vague and wordy. Intent seems good but the devil will be in the detail. The College and Nedical Council remain unaware of GP time pressures that make us resent the extra workload of recertification, and cynicism over perceived lack of reality to our daily tasks.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Address the perceived crisis of relevance. For GPs to actually believe in this overblown process, implementation needs to be to the point, targeted and seen as relevant to GPs. Final decisions need to be subjected to a vote by GPs.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

GP cynicism, a feeling of irrelevance and overwhelming time pressures. Each practice needs face to face visits to inform us and allow the chance for feedback.

Q4 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?

Face to face practice visits by College/Medical Council to prevent further erosion of our time off.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

A log of attendance at approved education sessions. Monthly peer group attendance.

Q6 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?

Monthly Peer group activities

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

As previously said, many of us resent the College and Medical Council's perceived lack of awareness of how precious our down time is. They fail to realise that excessive demands on our time for activities drawn up by non clinicians leads to anger and a crisis of relevance. Please simplify and target assessments with this in mind!

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

Rachael Crombie

From: Matthew Croucher [redacted]
Sent: Wednesday, 31 October 2018 10:49 a.m.
To: Strategic Consultation
Subject: Feedback: Strengthening recertification for vocationally-registered doctors

Categories: Blue Category

Thank you for the opportunity to provide feedback on the current consultation document. I am happy for my submission to be in the public domain.

I am a vocationally registered psychiatrist enrolled in the RANZCP's Continuing Professional Development programme.

At present the only gap in the RANZCP's CPD general bi-national requirements that doesn't meet the MCNZ's requirements (or its proposed future requirements) is the requirement for participation in an annual audit of practice. NZ RANZCP Fellows are very well aware of this and the College highlights it on their CPD pages.

In terms of the MCNZ's proposal, I cannot identify any new requirement or focus that is not already part of the RANZCP's programme.

My own suggestion that would add to both the RANZCP programme and MCNZ requirements would be for each organisation to provide a small range of easily downloadable instruments / supporting documents that we could use to formally elicit and analyse multi-source feedback or indeed to conduct our own 360 review. I am interested in doing such a review again, having organised my own some years ago. Searching the RANZCP and MCNZ websites for the terms "360 review" and "multi source feedback" currently yields no hits that lead to actual tools or instruments, let alone helpful advice.

The diagram on p10 of the consultation document is excellent. All clinical directors / managers should have access to it (with the rider that the purpose of clinician annual reviews is to support / enhance / build SMO professional development rather than assess / criticise / measure work output.

My final submission into this process is that although I support the introduction of voluntary RPRs into the suite of options, it would be easy for these to be poorly done – both too judgemental and too cursory / rubber-stamping outcomes being high risks, especially in the hands of untrained or poorly trained reviewers and especially if participation was mandatory. For well-trained reviewers and positive reviewees, the opportunity costs in terms of time that could be spent trying to keep up with the ever-increasing job demands are very high. Therefore it is important that this remain optional and the councils and colleges consider promoting methods of carrying them out voluntarily that are streamlined, effective, and evidence-based. Once again, having readily accessible guides on the relevant websites would be ideal.

Regards, Matthew.

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 7:22:14 AM
Last Modified:	Friday, September 07, 2018 7:41:46 AM
Time Spent:	00:19:31

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It seems misguided. There is a current and looming shortage of doctors.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I suggest it be left unchanged. Where is the evidence that the current arrangements are not working?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The challenges are the great lack of resources both financial and human to make such changes.

Q4 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?

They are out of touch with workforce reality on the ground. The locum shortage is already at crisis level.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Probably. But absolutely not if it is made more onerous than it already is. People have families that need them too don't forget.

Q6 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?

Peer review groups that we already organize, exactly as at present.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

You lack the necessary flexibility and understanding of doctor stress and wellbeing, and so sadly you will probably insist on increasing the burden of recertification beyond what is reasonable and appropriate. If it ain't broke don't fix it!

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 11:44:07 AM
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Time Spent: 00:03:31

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

agree

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

need to consult with the colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes-- compliance if they are too complicated

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

no

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**Neil DAwber**
Company	**NDHB**
Email Address	[redacted]

Q9 Your position/title:

Radiologist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 10:15:09 PM
Last Modified: Thursday, September 06, 2018 10:22:16 PM
Time Spent: 00:07:07

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Overall sound but colleges would need some control as each profession different

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Colleges will need to drive this. Enough stress and onus on medical staff as it is.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As a self employed GP with a young family I get zero money to support my CPD requirements. Hospital staff get significant reimbursement towards completing this for example attending conferences. When I sat my fellowship exam it cost me $2000. Hospital registrars get all of this back. I'm concerned about the cost of RPR in GP and who would cover this. It may force more GPs out of the field.

Q4 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?

Personally I think the NZ college does very little to support GPs and provide help/options for CPD.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I think patient feedback is key and more importantly peer feedback. What do my patients and colleagues think of me as a doctor/GP.

Q6 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?

Cost involved

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:30:28 PM
Last Modified: Thursday, September 06, 2018 5:43:59 PM
Time Spent: 00:13:31

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Agree largely but not all of them

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Feedback from patients is biased. If GP does not give Sickness benefit nor ACC benefit, patient can give degrading remarks

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes, Resources are limited and the GP & patient to get scans etc done

Q4 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?

Patient feedback should be abolished. The popular doctor is not necessarily the best doctor

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

PDP

Q6 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 an option only

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

GP's work under increasing pressure due to inability of secondary & tertiary services long waiting lists. Any excess demands will lead to premature retirements from GP's

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, November 03, 2018 12:19:11 PM
Last Modified: Saturday, November 03, 2018 12:26:18 PM
Time Spent: 00:07:07

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am not sure if the new pathway will allow the SMO to grow outside of his/her narrow scope. For example - I graduated as a Child Psychiatrist. After a decade of practice, I started learning about Health IT and participated in conferences and courses, some supported by my CME framework. If i was not allowed to do so, there was no chance for my hospital to have a Chief Medical Information Officer. And I know of many other doctors who expanded their practice to include Public Health knowledge, or certifications from other colleges(for example: A GP going through courses of procedures in Dermatology, etc. We need to make sure that the new pathway will not limit those important endeavors outside of your original scope

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Should a SMO choose to expand his/her knowledge/practice beyond the original scope (as viewed by the college), then he/she should have a pathway to explain their goals to their respective line managers, and have the option to be approved to do so (as per the manager's discretion)

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I am not sure.. the proposed plan is very much high-level..

Q4 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?

Time ! you really need to make sure that there will be no additional time required for completion of CPD requirements. We are all overworked as it is, and there has to be a proper balance between CPD requirements, and face-to-face time spent with clients

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Not sure what you're asking.....sorry

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

NA

Page 2: Submission information

Q8 Your information:

Name	**Yariv Doron**
Company	**Taranaki DHB**
Email Address	[redacted]

Q9 Your position/title:

Dr (consultant)

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 12:28:59 PM
Last Modified: Monday, September 10, 2018 4:55:43 PM
Time Spent: 04:26:43

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I have to admit that I see little yield in that, with all due respect. I have been working in several countries, with and without extensive reciertificaiton (including the USA where you have to be re-examined every few years). I have never seen any major progress or deterioraiton inthe overall outcomes of the health system I worked in, as correlated to the presence (or lack of) recertificaiton. If anything - it adds more unnecessary pressure, "steals" valuable time from doctors who are already overworking, etc.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I fail to understand what is missing in today's already cumbersome system. There is so much CME going on, and everything is reported to the most tiny detail. I fail to see what is the gap that the MCNZ is so eager to fill, with the excessive extra work.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes ! Time being the number 1. Please understand the immense burden that we are under. Doctors around me (including myself) are burdened with so many tasks and little time. We are nowhere near to address all the needs of the community. Nwo we will have to direct more time to reporting, auditing, going through audits and providsing audits to others. This is counterproductive to our core business, which is attending to other people. If we truely want to improve the medical outcomes in NZ, we should use our resources wisely, and not spend them on additional auditing.

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No ! I feel that there is a major CPD work around as it is, with numerous reporting lines. PLEASE DON'T ADD MORE !!!!

Q6 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?

Yes. As I said earlier - we are all overworked, and I cannot see myself dedicating more of my non-available time to more CPD

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No, thank you

Page 2: Submission information

Q8 Your information:

Name	**Yariv Doron**
Company	**TDHB**
Email Address	[redacted]

Q9 Your position/title:

Consultant

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 9:44:16 PM
Last Modified:	Thursday, September 06, 2018 10:11:55 PM
Time Spent:	00:27:39

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

In general this approach appears feasible

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The recertification college needs to produce a general guideline of requirements which the individual doctor can use to develop a plan to comply as well as this being useful for own practice setting

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

While doctors may have a general or vocational registration there are an increasing number who develop knowledge and strength in more restricted fields hence the requirements need to be sufficiently flexible to cover the individual's and his/her patients needs.

Q4 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?

If Providers will be expected to individualise requirements this will increase work load

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME in their practice needs. Some sort of ethical assessmdnt. Patient satisfication questionaire for each doctor. Auditing on outcomes in treatment of patients. A practice assessment visit should be optional for full recreditation.

Q6 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?

I think this is a good option but will need senior credited impartial doctors to do the assessment. This with patient satisfaction questionaires and an audit based on outcomes i see as main elements.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Take it slowly and allow doctors leeway to make decision on options available. Really most doctors are very responsible and capable but maybe there needs the ability to have a mentor system for those needing help in the process or where a deficiency is perceived

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 1:39:13 PM
Last Modified: Friday, September 07, 2018 2:09:16 PM
Time Spent: 00:30:03

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

For small (in number of specialists) disciplines there needs to be options to accomodate the way we work. For example peer review is more difficult (but can and is done) to arrange due to the small number of chemical pathologists seperated from each over (small number in each major centre). This will also may regular practise review more difficult when compared to some of the other areas.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I do not really know. The role of the colleges will be important

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Keep in mind challenges for specialists working alone or with only a small number of other specialists in new Zealand - needs to be practical

Q4 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?

No concerns in my area

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. Should be targeted to the discipline. May well be that there are many activities that are common but the requirement for activies should be based on need.

Q6 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?

I think the RCPA is doing a good job in my area. The peer review only needs refining, again mostly relevant for the smaller disciplines

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**Stephen du Toit**
Company	**Waikato DHB**
Email Address	[redacted]

Q9 Your position/title:

Chemical Pathologist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 7:38:16 PM
Last Modified: Thursday, September 06, 2018 7:42:12 PM
Time Spent: 00:03:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

bad idea

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

wind back requirements

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

irritating.Why not review in 10 more years.

Q4 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?

abandon recertification

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

yes, clumsy.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

abandon the whole program

Page 2: Submission information

Q8 Your information:

[redacted]

Q9 Your position/title:

Semi-retired

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, September 12, 2018 11:47:25 AM
Last Modified: Wednesday, September 12, 2018 1:11:58 PM
Time Spent: 01:24:32

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think they are more practical and helpful and should be considered as soon as possible, particularly the multisource feedback and practice visit

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The council established a working model for recertification programme and its key components that can be easily recommended or employed even with some modification if required. I am referring to the "Inpractice Recertification programme for generally-registered doctors that were introduced in 2013". Most doctors will agree that expectations should be the same across the board regardless of the type of registration (vocational or general). It should be about strengthening the recertification process for all doctors (practitioners) rather than recertification based on their registration.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The changes if any should be part of the programme requirement and can be introduced accordingly as this process of recertification will always have its proponents and opponents

Q4 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?

The colleges are soemtimes particulaly slow in introducing changes and should be prompted to do so.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

The components that seem less appealing but some doctors have already been made mandatory for other doctors on the basis of their registration ie vocational vs general. The same should be applied to all or none.

Q6 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?

A small group of 7-8 colleagues, holding monthly or twice monthly meetings. I do not foresee any issues for RPR as an option. Some doctors are reluctant due to time and process required for the arrangement and undertaking of the RPR.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The sooner the better, delaying is not going to make the implementation smoother or more acceptable.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, September 24, 2018 5:25:51 PM
Last Modified:	Monday, September 24, 2018 5:34:00 PM
Time Spent:	00:08:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think being systematic is quite good but for many people working in tertiary practice a lot of self and peer review happens as part of practice and in a busy life it can be quite hard to complete formal requirements

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

it is has got to be easy to comply without extra effort. I am not clear we need to do a yearly audit. as an approver of audits I see some audits being done that have little meaning just to complete requirements.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

We are all time poor

Q4 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?

I think access to ongoing CME is important but I find the requests to reflect on what I am doing annoying. That goes on in my head all the time.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I think you need to be seeing patients regularly and going to some educational events

Q6 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?

What is RPR - perhaps I was reading too fast!

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Just keep it simple. We are all busy and the majority of us try very hard to keep up to date

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, September 12, 2018 5:33:44 PM
Last Modified:	Wednesday, September 12, 2018 5:36:15 PM
Time Spent:	00:02:31

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q9 Your position/title:

Dr

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Friday, 7 September 2018 8:47 a.m.
To: Strategic Consultation
Subject: consideration for MOSS roles

Categories: Blue Category

Dear MCNZ,

Please could you look at MOSS roles working within a DHB and also those working in a very narrow field of medicine.

In my case, working as a MOSS for a DHB, everything I do is supervised. I receive CME allowance to attend conferences and attend regular in-house meetings. When working more than half time I have no issue with the inPractice programme. However I have recently struck an issue when considering reducing to 2/10 clinical work. I still have to fulfil the full CPD requirements despite being fully peer reviewed in my role.

The current system is too rigid and for my circumstances and the amount of CPD work required for so few hours is not worth me continuing in the workplace. As a MOSS every consultation is reviewed by a colleague. I attend regular meetings and conferences. A simpler form of CPD would suffice. I fully support CPD but the requirements need to be more flexible and relevant to the specific role. My personal field of work is very narrow.

I also work in another very narrow field as [redacted]. If I were to reduce my work to only this field, I would not be able to find enough activities to maintain my CPD.

Whilst there may not be enough doctors working as a MOSS to make this field relevant to the Council to look at, I feel a separate category/ some flexibility of the requirements should be incorporated for us outliers. Each case could be assessed individually and a more relevant CPD programme decided upon. I am suggesting that the CPD requirements are individualised to the specific role on a case by case basis.

On a personal note, my CPD requirements are the sole factor for me considering not maintaining my registration as I wish to take on further study next year. The CPD requirements are too onerous to manage along with full-time study. There was no flexibility applied to my case when I discussed it with the Council and I am sure that my DHB colleagues will be horrified if I resign.

Whilst this review will be too late for me, given the dwindling workforce issues and the ageing workforce, I think that the Council needs to incorporate some flexibility for us " worker bees" that work in limited field,one-off supervised roles within the Health Service.

yours sincerely

name withheld

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:32:49 PM
Last Modified: Thursday, September 06, 2018 5:41:20 PM
Time Spent: 00:08:30

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

This makes me feel apprehensive. When revalidation came to the UK, it has mostly been a useless box-ticking exercise that does little to discriminate between good and poor practices.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The programme would have to be relevant to the doctor and their specific work

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. For doctors in private practice, peer review (other than the monthly group type peer groups) is harder. As a psychiatrist mostly doing sensitive claims work for ACC, my clients would almost certainly not tolerate having an observer or video or their interviews about their rape, etc

Q4 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?

As a sole psychiatrist in private practice interviewing trauma victims, how would I be able to meet requirements for the practice visit/ review?

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. It depends on the doctor’s type of work

Q6 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?

Being interviewed by someone from the Royal College in my office.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don’t set doctors up to fail by being too rigid in what is required

Page 2: Submission information

Q8 Your information:

Name	**Amanda Faulkner**
Company	**Private practice**
Email Address	[redacted]

Q9 Your position/title:

Consultant Psychiatrist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, November 01, 2018 6:05:19 PM
Last Modified: Thursday, November 01, 2018 6:19:36 PM
Time Spent: 00:14:16
[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

All seem valid in an overarching theoretical sense; but also come across as very vague and lacking specifics. These exact same concepts have been bandied about for years now by MCNZ, and with little concrete progress on exactly how the New recertification programme wiLl be run

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Since we are now behind the Australians / AHPRA in this space; could you please, please, PLEASE just align with them, so we don't end up with unwieldy different but similar programmes. The vast majority of specialist colleges cover both countries after all.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Hard to know; when NO specifics have been offered. The big one would be RPR, which may be potentially very onerous to run, but the devil as always is in the detail.

Q4 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?

Will MCNZ align with AHPRA, or will they be pig-headed, ignore APHRA and come up with their own but different enough programme, that then requires the colleges to run two systems. What does RPR entail PRACTICALLY. Solution = just copy the Aussies

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Audit

Q6 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?

For radiology - remote external review of cases and their reports would be best - needs to be an achievable number. There are of course major potential issues, especially if external review is required, and particularly for those specialities where this will need to be 'onsite'

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Specific details need to be fleshed out; and then a further period of consultation. It's very hard to comment on vague concepts, when the detail is what might lead to a less smooth implementation. The coll gets will then need an adequate period to adopt any changes - adequate being several years notice, NOT several months.

Page 2: Submission information

Q8 Your information:

Name	**Joe Feltham**
Company	**CCDHB**
Email Address	[redacted]

Q9 Your position/title:

Consultant radiologist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, October 01, 2018 11:28:23 AM
Last Modified: Monday, October 01, 2018 11:32:38 AM
Time Spent: 00:04:15

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

generally sound and reasonable

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

none, but they shoyuld be incorporated into usual clinical practice as nuch as possible

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. More resources with things such as MSF. Also ensuring anonymous feedback can be challenging

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

we already have a programme in place. I would also welcomean observer type approach but this would be resource intensive

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**Valerie Fletcher**
Company	**Canterbury DHB**
Email Address	[redacted]

Q9 Your position/title:

SMO General Medicine and Older Persons Health

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 3:51:23 PM
Last Modified: Monday, September 10, 2018 3:59:54 PM
Time Spent: 00:08:30

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Don't have practice visits . Obtaining up to date information gathering by G.Ps at cost/ no price should be the basis of recertification

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't have practice visits ,too stressful and also interview techniques were studied at med school. Problem solving is based on information so education re new medical developments should be the basis of recertification. Don't do feedback questionnaires , too much time wasted

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As above , feedback questionnaires , inpractice visit and audits waste too much time and rather pointless, please stop them now.

Q4 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?

As above

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Education

Q6 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?

Only have collegial get togethers and peer groups.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The more stressful you make it and the more onerous and time consuming the less hours doctors do and the more deaths result .Education is key

Page 2: Submission information

Q8 Your information:

[redacted]

Q9 Your position/title:

Dr

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Monday, 10 September 2018 2:50 p.m.
To: Strategic Consultation
Subject: Recertification
Attachments: 2018-Discussion-document-strengthened-recertification-FINAL.pdf; ATT00001.txt

Categories: Blue Category

Dear Carol/team, the Medical Council not long ago passed a law to ban all G.Ps who don't refer a woman to help her kill her unborn baby (termination of pregnancy) from practicing medicine. Only by a court case were those G.Ps defended and the unjust law struck down. How can we fully trust someone who comes to our practice to monitor us? This part of the recertification should be abandoned. The ability to interview patients was done at med.school and not forgotten. Decision making is based on knowledge and the medical knowledge base is always expanding. This should be the substance of recertification. Courses, specialist presentations (and attendance!)all at cost price should underpin / be the basis for recertification.
Regards
[redacted]

[redacted]

From: [redacted]
Sent: Thursday, 1 November 2018 9:00 p.m.
To: Strategic Consultation
Subject: Recertification

Dear Carol and team , I think with recertification we should:
1. Get rid of patient practice surveys, they waste too much time.
2. Get rid of practice visits, they are to stressful. Remember the Medical Council tried to ban doctors from practicing medicine who would not refer a woman to terminate her unborn child's life .Until the court overturned their efforts the law would have been drastic for many doctors. How can we fully trust practice visitors?
3.Peer get togethers with specialist speakers are excellent for learning new info. These should be encouraged but lately my group seem to have fallen away from informing me when they are meeting!?
4. Conferences are excellent ways of learning new info. especially with specialist speakers. However often they are costly! Let's keep costs down eg use the University of Auck campus?
5. Audits by G.Ps take far too much time let's scrap them .
6.There is far too much cultural stuff , it could be summarised with Jesus' words" do unto others as you would have done unto yourself " with maybe a 1-2 hour cultural workshop once a lifetime or every 3 years !
7.The BPAC programme and NZRCGP programmes cost too much.
8. Our CME programmes should count if we work in Aust . Ie so we don't have to do a ROMPS program or get a 20% reduction in pay over there. Can you please organise that!?
Regards
God bless
[redacted]

[redacted]

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Last Modified:	Wednesday, October 31, 2018 1:30:04 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes, I think there should be a yearly standard for all doctors to complete. This should represent our main morbidity problems e.g. cardiology - heart failure, AF or other to be determined focus areas that could change yearly. the PHO's should then have to provide mandatory training that needs to be visited...

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Dr. Stefan Freudenberg**
Company	**The Doctors Napier**
Email Address	[redacted]

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 11:45:27 AM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

i am interested and welcome this .

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

individual gp to decide a variety of options, Webinars, Access to online Journals and ? collaboration with our colleagues in Australia and UK?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Its is an individual driven process , and Gp vary in their approach.

Q4 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?

cost

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes ,can cover all major sub fields of General Practice .

Q6 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?

practice visit, notes audits etc.unsure at present

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

not at present

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: Brigitte Gertoberens (ADHB) [redacted]
Sent: Wednesday, 31 October 2018 4:17 p.m.
To: Strategic Consultation
Subject: RE: MCNZ - Strengthening recertification for vocationally-registered doctors

Dear Andrew,
It is for sure a priority of the MCNZ (and comparable institutions in other countries) to make sure that registered medical professionals keep up to high standards and practise safely. Most specialists will have to meet their Faculty's or College's CPD requirements which are usually high. Whatever the MCNZ would require ,I would need to fulfil the CPD requirements of my Faculty to maintain my membership . To my knowledge the Faculties review and change regulations quite regularly.
What we cannot directly control is work environments /conditions e.g shortage of staff or management requesting appointment times to be shortened – factors that may put patient's safety at risk.
With kind regards

Brigitte Gertoberens
FFPMANZCA| Pain Medicine Specialist
TARPS - The Auckland Regional Pain Service.
[redacted]

From: Medical Council of New Zealand [mailto:sconsultation@mcnz.org.nz]
Sent: Wednesday, 31 October 2018 9:00 a.m.
To: Brigitte Gertoberens (ADHB)
Subject: MCNZ - Strengthening recertification for vocationally-registered doctors

Dear Colleague,

For a number of years now, the Medical Council of New Zealand (Council) has been working towards strengthening how we ensure doctors practising in this country are up to date and continue on the path of lifelong learning.

Recertification is a process that gives assurance to Council, medical colleges, and most of all to members of the public, that doctors are undertaking activities to ensure they remain up to date and provide opportunities for continued professional development.

You may be aware that Council has been consulting on recertification. The current discussion document, which is out now for feedback, is the culmination of extensive consideration, discussion and research. It provides context of where we have come from, what the evidence tells us about what works (including a literature review undertaken to consider this), and proposals for where we could go next.

I would encourage you to read the newsletter which contains further information around recertification at the link below. You can also find further information about the consultation on Council's website.

[redacted]

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Started: Thursday, September 06, 2018 9:54:14 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Generally good, appreciate evidence based and careful review of usefulness for practice

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Smaller bites might be easier - no eason this has to be annual, could be 4 monthly touch base with smaller requirement on each interaction.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Sufficient time to dedicate to completing requirements adequately

Q4 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?

Colleges often forget NZ in planning and implementing any programme

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Resusc basic training. `public have an expectation that we can do this at any point as doctors. Regardless of specialty we should all be the best available bystander. Cultural competency. And some sort of reflection on whether we are self aware enough to self care. `if recertification is to ensure a doctor is fit to practice this should also include some measure of wellness to practice by checking for signs of self awareness around wellbeing and mental health,

Q6 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?

part of our regular practice so no issues seen

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

`ensure a functional app that can measure, store, monitor and submit relevant details

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 10:30:11 AM
Last Modified: Wednesday, October 31, 2018 10:40:44 AM
Time Spent: 00:10:32

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

if we are going to try to improve first we need to know where we are, the "audit" process is very weak it will need to be markedly improved with infrastructure that allows prospective data collection.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

see above

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

see above. time will need to be given in a job plan to allow for data collection and analysis

Q4 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?

Avoid duplication the NZOA and RACS already have CPD and visitation programs

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Audit

Q6 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?

Comprehensive visitation as per NZOA has at present

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Nigel Giles**
Company	**BOPDHB Whakatane Hospital**
Email Address	[redacted]

Q9 Your position/title:

Consultant Trauma and Orthopaedic surgeon

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 5:11:01 PM
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Time Spent:	00:52:19

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

the core components are sensible

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

When the APC application is made each year, the Council could request evidence of compliance

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Expect resistance from some, but if the demands are reasonable, flexible, and appropriate to each practice, it should be OK. The recording and provision of documentation needs to be all online, preferably updatable during the year as requirements are met....

Q4 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?

The RACS program for Plastic Surgery is excellent. 4 categories : Maintenance of knowledge and skill; clinical governance and quality improvement; reflective prectice; peer reviewed audit. The activities can be entered online, documentation uploaded etc..

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

College approved CPD - the meetings must meet the criteria for CPD points.

Q6 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?

Practice review is impractical, and could be reserved for doctors who fail in some way - e.g. at the direction of the HDC, or even at the request of the doctor, or MCNZ. I would have reservations about a practice review, depending on the reviewer, and his currency etc..

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**David Glasson**
Company	**Plastic Surgery Specialists**
Email Address	[redacted]

Q9 Your position/title:

Plastic Surgeon

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, September 30, 2018 5:49:37 AM
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Time Spent: 00:58:07

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The reasons for "strengthening" the current process are unclear. There is no demonstration of a crisis of "trust" in the medical profession. Whilst there is no evidence that our current CPD system is fulfilling "the vision", there is no evidence that it is "broken". Since we haven't really assessed the benchmarks of quality in our existing system that need to change, it is difficult to project what might be achieved by "strengthening" our current system of recertification. It seems to be motivated by "me too" sentiment or "change for the sake of change" rather than an actual failure of the existing system. I am concerned about the very limited pool of peer reviewers who would be able to serve in the RPR process, which could be used to thwart competition or promote mindless conformity with corporate medical interests.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

These should be completely voluntary for an interval of 5 years. Key quality indicators should be benchmarked during this time and a comparative analysis between those participating and those not participating in the process should be analyzed to assure that such heihtened scrutiny of medical practitioners is in fact in the public interest and justified.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time constraints on physicians may limit their ability/capacity to engage in more layers of bureaucracy whilst their wait lists expand. How will service delivery be improved (ie more time with patients, and reduction in wait times) when physicians are wasting time to fulfill the potentially unjustified heightened scrutiny requirements of an ever-axpansive bureaucracy? How will patient privacy be protected if the RPR process takes place by physicians not involved in the patient's care? Who will oversee these additional processes? Will it expand the Medical Council and add to the cost paid by doctors for their annual registration, or the burden upon taxpayers to increase funding to the Ministry of health? In the absence of evidence of need for the proposed changes, the changes should be cost neutral to the NZ tax payer and the doctors being regulated (in terms of time and financial outlay for ongoing certification).

Q4 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?

In the interest of relevance and practicality, efforts should be made to streamline processes for doctors and preferably work towards a "commonwealth" certification that incorporates evidence-based components from the UK, Canada, Australia. As a country with a smaller tax basis, it will be important for NZ not to be forced to comply with procedures and medications that have not been approved in NZ due to cost constraints. Physician burnout is a very real cause of medical errors and poor performance. I daresay that most physicians are burnt out with the ever-changing goal posts created by government regulators that do not make us better doctors or add value to our patient care. Hopefully, the pendulum will swing the other way soon as more physicians begin to push back or leave the profession. If the primary regulators do not take heed of this concern, I predict that they will begin to see their base erode, as has the American Board of Medical Specialties.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Review of proper antibiotic prescribing every 5 years. Review of opioid prescribing every 5 years. ACLS/BLS every 3-5 years. Annual anonymous survey of physician job satisfaction with an opportunity for feedback by doctors to the medical infrastructure in which they work.

Q6 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?

Who will be the "recertification providers"? Again, NZ has a very limited pool of potential peer reviewers who may have conflicts related to competitive practices or simply "insider versus outsider" political games. How can the neutrality of recertification providers be trusted? We already have built in peer review processes in our practice without havin "recertification providers" woven into another layer of bureaucracy.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Please reflect upon whether this is actually needed. Although the proposal is worded in terms of flexibility, I am concerned that this could morph into a sort of "Maintenance of Certification" nightmare that was put forth by the American Board of Medical Specialties in the last decade. Physicians hated it and it did nothing for patient care. The reasons for making any such changes should be clearly understood by the Council and conveyed to NZ doctors. There has been no clearly articulated problem with our existing certification process. The Council shuld make a business case for this proposal with the additional costs of implementation clearly stated. We cannot simply assume that this is about "protecting the public" and accept "whatever the cost may be" unless there is a clear problem with our current system.

Page 2: Submission information

Q8 Your information:

Q9 Your position/title:

NZ doctor

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

Medical Council Strengthening Recertification for Vocationally Registered Doctors

Dr Ben Gray

Legislation

The Medical Council's responsibility is to implement the legislation. Section 118 outlines the responsibilities of "Registration Authorities"

118 Functions of authorities

The functions of each authority appointed in respect of a health profession are as follows:

(a) *to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes:*

(b) *to authorise the registration of health practitioners under this Act, and to maintain registers:*

(c) *to consider applications for annual practising certificates:*

(d) *to review and promote the competence of health practitioners:*

(e) *to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners:*

(f)*to receive and act on information from health practitioners, employers, and the Health and Disability Commissioner about the competence of health practitioners:*

(g) *to notify employers, the Accident Compensation Corporation, the Director-General of Health, and the Health and Disability Commissioner that the practice of a health practitioner may pose a risk of harm to the public:*

(h) *to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession:*

(i) *to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession:*

(j) *to liaise with other authorities appointed under this Act about matters of common interest:*

(k) *to promote education and training in the profession:*

(l) *to promote public awareness of the responsibilities of the authority:*

(m) *to exercise and perform any other functions, powers, and duties that are conferred or imposed on it by or under this Act or any other enactment.*

This discussion document provides good coverage relevant to section (d), (e) and (k). A central part of this document should be to respond to the provisions of section (i) There is limited reference to cultural competence and no reference to ethical conduct.

Recertification "Therapeutic not Diagnostic"

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". (p3)

Considering the legislation above recertification has to be both "therapeutic" and diagnostic" Quality improvement is therapeutic, quality assurance is diagnostic. Quality assurance is determining whether the quality of care provided is above a minimum standard. This is required to meet section (i)

Quality Assurance

Nowhere in the discussion document is there a clear statement of the circumstances when a doctor would not be re-certified; what the minimum standard ought to be. The statement "*Must enrol and actively participate in a Council accredited recertification programme relevant to the vocational scope of practice in which they are registered*" implies that a doctor who does not "enrol and actively participate" will not be recertified but is that the only thing? Is there a requirement to "adequately" participate in such a plan? Are the Colleges expected to report on inadequate participation and if so on what basis does this happen. Surely such a document should include reference to grounds such as being struck off by the Health Practitioner's Disciplinary Tribunal, or being found guilty of particular criminal offences. There has to be a summative element to the process

Quality Improvement

Quality improvement is a difficult concept.

It requires a definition of what quality is…which is situation and task specific, let alone based on values and beliefs of the patient and the doctor. It is not some agreed objective standard.

It is inevitably based on the premise that quality can be measured (how else would you know it had improved). In my daily practice many of the best things I do are based on the quality of the relationship I achieve with my patients which is essentially unmeasurable. Even if it was measurable to make a judgement of whether I was good or bad you would have to compare me to others. How do you decide what a reasonable control would be?

The other problem is that not only do I have be competent but I have to document that I am competent. Our practice has just had its accreditation visit for the RNZCGP Cornerstone programme. We were criticised because we did not have sufficient documentation of all staff having attended accredited training on Cultural Competence. We care for one of the most ethnically diverse practices in the country. 40% of our practice population come from a refugee background. I personally have convened courses on Cultural Competence and teach this curriculum to medical students. Two of my colleagues run a post graduate paper in Refugee Health. We employ interpreters probably more than any other practice in the country. I have no certificates saying I have attended training in cultural competence. The lack of certification bears no relationship to our ability to care for a culturally diverse practice. The accreditation of training in Cultural Competence is inevitably flawed because measuring meaningful outcomes from such training is almost impossible. If care improved (whatever measure you might use) it would be hard to know whether it was related to the training. If care did not improve it might be to do with factors outside of the control of the practice. Designing and implementing meaningful evaluation of a programme would be expensive complicated and unreliable. But you can measure whether people have certificates.

It is in this sort of circumstance where it is important to distinguish between quality assurance and quality improvement. I am reasonably familiar with the literature on Cultural Competence and there is a dirth of good evidence to show that any particular clinician focussed initiative improves health outcomes for cultural minorities. It is thus not possible for the College to only promote "evidence based" education on this topic. If the focus is one of quality improvement this is less of a problem. It may be hard to show that a particular training module on working with an interpreter leads to better outcomes for my patients, but as a professional I can make my own judgement of what is of value. The problem with this is if the requirement for doing this summative; quality assurance. In this instance our practice accreditation would not go through without providing the required evidence. I believe strongly in engaging in quality improvement activities. I think that a requirement to *"enrol and actively participate* in an accredited recertification programme that has a requirement to be engaged in quality improvement is an essential pre-requisite of being recertified. Failing to provide evidence of having attended a particular programme is very poor evidence to use to determine whether I am competent to practice.

Language used and Complexity Theory

There is no doubt that the task of determining whether a doctor is fit to practice is a complex task. It will involve assessing multiple streams of information, with significant amounts of uncertainty as to validity, against a hard to define "standard" of acceptable quality. In my view it is therefore not going to be possible to define "best" practice or even "good" practice in this area. These are terms best used in relation to "Simple" and "Complicated" problems but not to "Complex" problems like this[1] [2] New Zealand will have particular views about what a "competent" practitioner might be. Whilst there will of course be overlap with other jurisdictions there will be different weightings on different components and there may well be some New Zealand specific components. An understanding of the Treaty of Waitangi would be a good example. We will always have iteratively emergent practice.

Answers to Questions

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

I think that the approach should be structured according to the legislation with clear sections on what are the "*standards of clinical competence, cultural competence, and ethical conduct"* that are separated out from the section on *"review and promote the competence of health practitioners and to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners*

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

If the requirements were separated out as discussed above it would be much easier to be clear what the "minimum" is in order to be recertified, from what activity should be undertaken for quality improvement. Especially for General Practitioners this is a very difficult task. The range of possible knowledge and skills that I might hold is so large that deciding what is "required" is difficult. The current approach of allowing the RNZCGP to make that call is satisfactory

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

The main challenge as discussed above is the pretence that there is evidence supporting any particular continuing education initiative. The level of evidence available relative to any particular practitioner is far from high level.

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?

I have confidence in RNZCGP to manage this effectively

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

No. For many years the RNZCGP has had mandatory resuscitation training as part of the accredited programme. I have not needed to use those skills for the past 25 years. Like riding a bicycle I will always retain some skill. We used to spend a lot of time practicing intubation on dummies. I have in fact never successfully intubated anyone, and the practice on dummies seemed unlikely to help. The most recent course has abandoned that approach acknowledging that it is not effective. The range of circumstances in which doctors practice is too wide for it to be sensible to have any mandatory requirement.

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?

We currently have an annual performance review performed by our senior doctor on all the other doctors. We combine this with completing our Practice Development plan for the RNZCGP process and it works well. Given that the GP workforce is under major stress at the moment due to numbers retiring I have major concerns about utilising a lot of time of senior GP's doing RPR's and 360 degree feedback is only useful if people have the time to engage properly and give considered feedback. I have no objection with having this as an option for those who are able to set it up but do not see it as a viable strategy for all

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

Nothing in addition to the above.

1. Snowden DJ, Boone ME. A leader's framework for decision making. *Harvard Bus Rev* 2007;85(11):68.
2. Gray B. The Cynefin framework: applying an understanding of complexity to medicine. *Journal of Primary Health Care* 2017;9(4):258-61.

[redacted]

Collector: Web Link 1 (Web Link)
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I oppose them. The proposed approach will add huge compliance costs without materially improving patient safety or outcomes.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't do it. The proposal is based on extremely weak or nonexistent science, and is trying to fix a problem. The current recertification programme is _not_ broken. It does not need to be fixed or improved. I have carefully read and reflected on the evidence that is said to support the changes. I respectfully submit that the evidence is wholly inadequate to justify the new system.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. It is a huge amount of extra work that will inevitably impact on our ability to deliver current clinical work. There is no expectations that our employers have many any provision to account for this cost in time. Given the absence of convincing evidence that the proposed system will improve any outcomes, it will be difficult to persuade people to engage, or commit the necessary time.

Q4 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?

I am a specialist. the College does not and never has provided a curriculum; we the expert members of the college do this. in reality then the programme will require us to develop a new programme and then submit ourselves to it. I recommend not undertaking this wholly unneeded and useless activity

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No.

Q6 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?

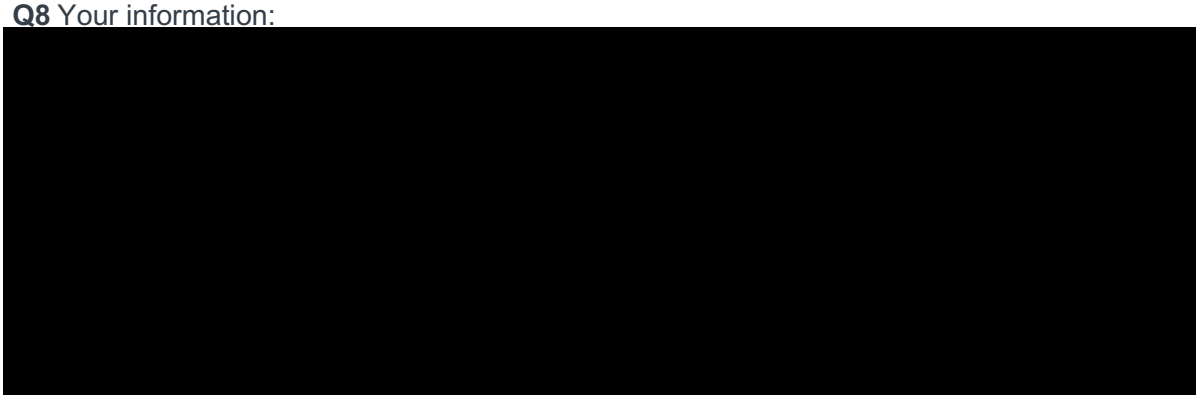
I undertake regular audit of specific outcomes of our patients, and present challenging cases and adverse outcomes to our specialist group. This is valuable because it allows mutual critique and evaluation. No reasonable person will do this if it would lead to medicolegal implications. It is essential that all participants feel able to be open and collegial.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Yes, please don't do this. The proposal is based on a weak and highly contentious evidence base that will expose the profession to a high degree of wasted effort.

Page 2: Submission information

Q8 Your information:



Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
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Time Spent: 00:04:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think it's good. I am pleased exams are not included. I agree with the formative vs. summarise approach. I think that supervision or some kind of supportive reflection should be mandatory to help improve Doctors's ability to debrief. It needs more focus on physician well being as it is critical to good patient care & outcome

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

It would be difficult if RPR were mandated in my specialty as the number of people needing recertification is >700. Even if only done every 5 years that's a minimum of 140 days of work lost

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. People will be annoyed they have to do more paperwork

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes, ACLS. And clinical supervision

Q6 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 above. So many person-hours needed

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**Kathryn Hagen**
Company	**ADHB**
Email Address	[redacted]

Q9 Your position/title:

Specialist Anaesthetist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:21:26 AM
Last Modified: Friday, September 07, 2018 9:29:44 AM
Time Spent: 00:08:18

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

sounds good

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

programmes should be relevant to the doctor's actual workplace and career place

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

not at this point of time

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

the current peer review programms seem suffecient. RPR should be optional where peer review programmes are not avaiable

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**Amjad Hamid**
Company	**TDHB**
Email Address	**amjad_hamid@msn.com**

Q9 Your position/title:

SMO/Doctor

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:55:01 PM
Last Modified: Thursday, September 06, 2018 6:00:34 PM
Time Spent: 00:05:32

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

much of what is proposed is already carried out with vocationally trained orthopaedic surgeons in NZ , ie practice visits , a structured cpd programme

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Michael Hanlon**
Company	**Domain Orthopaedics**
Email Address	[redacted]

Q9 Your position/title:

orthopaedic surgeon

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:59:26 PM
Last Modified: Thursday, September 06, 2018 10:18:28 PM
Time Spent: 00:19:01

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It seems very much in line with what is already in place with the RNZCGP

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think that is best left to the colleges. I would avoid having to report to multiple agencies. For individual practitioners it would help to have some of the requirements funded rather than being another expense.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Right now, it's pretty redundant, so hopefully could fill requirements of the college and have good standing in the college represent compliance.

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review, BLS

Q6 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?

I am currently in a group that meets monthly. This is a group of GP's that formed their own group. This is has been very helpful. I'm not sure how RPR would work. I think it's important for small practices that it not be too costly.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I think working with the colleges would be most effective. The RNZCGP already has an extensive program and website that allows submission of required elements.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:08:45 PM
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Time Spent: 01:27:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Efficiency. Must not further deplete service delivery time as many other demands are already.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Use and work with current college recertification to avoid double jeopardy

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Failure to co ordinate is main risk if each tries to do it their way without compromise.

Q4 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?

Part timers and semi retired who have done a lot of this for years may quit with workforce implications.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review. CPR, practice certification for at least core standards. Regular attendance at clinical updates

Q6 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?

Needs to be local and accessible. Occasional outside input to help standards.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Lead off from current activities and consider issues for rural, remote and older practitioners

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:01:27 PM
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Time Spent: 00:04:04

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I have not read it

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I would like to read the key components

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No idea

Q4 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?

No idea

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes

Q6 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?

Ongoing CPD crucial. Peer reviewed programs a good component

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No idea

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:28:23 PM
Last Modified: Thursday, September 06, 2018 5:38:17 PM
Time Spent: 00:09:53

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

To be a devil's advocate I make the following points: firstly how much money has been wasted so far on this process? Since the council seems obsessed with buzzwords then where is the evidence that bringing in additional measures is going to make any difference in significant clinical outcomes?The colleges already have CPD programs. Nice, touchy feely PC surveys and peer review isn't likely to do anything more than waste time and money.Your discussion document is weak and fails to advance the case for changing anything frankly.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Dr Chris Hawke**
Company	**Hawke Urology Ltd**
Email Address	[redacted]

Q9 Your position/title:

Urologist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Friday, 7 September 2018 6:01 p.m.
To: Strategic Consultation
Subject: Recertification

Categories: Blue Category

I am curious that what is being proposed is already substanialy in place with my college ANZCA
I have a concern that as a part time practioner with no CME allowance from a DHB some activities incur substantial fees. Is there any consideration for this circumstance

Cheers [redacted]

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
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Last Modified: Thursday, September 06, 2018 5:31:02 PM
Time Spent: 00:07:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am very concerned that I would achieve 10 hours of peer review each year. My colleagues time is valuable and limited by workload demand. A more realistic goal would be 4 hours (e.g. a half day clinic).

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Reduce Peer review to 4 hours per year

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Colleagues time is limited and we are all really busy. Difficult to get 10 hours peer review every year.

Q4 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?

Peer review should be 4 hours per year. Or maybe have 12 hours every 3 years used as a 360 degree multisource feedback exercise

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

360 mulitsource feedback easier to organise than 1 colleague for peer review

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Need to find ways for doctors in private practice to do peer review

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 21, 2018 8:45:12 AM
Last Modified:	Friday, September 21, 2018 8:54:42 AM
Time Spent:	00:09:30

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

considered/ perhaps different for different stages of working life

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

may be more difficult rural vs urban areas and needs to be included in consideration of lots of aspects of this

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

again, will be more difficult for rural doctors vs their urban counterparts

Q4 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?

having easy access to a "go to person" in the admin part of the College involved with , for easy advice, thats not a medical colleague.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

cultural competence, have learnt lots personally thru this aspect which wouldn't have otherwise, Peer review group activites, now working more rurally, online PRG enables this aspect to be as easy as living in urban areas where routinely have other colleagues.

Q6 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?

no, use of ZOOM /other similar, make this easy now.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

ensure involvement with rural doctors as well as often its the more city based docs and assoctns that are spearheading these aspects and the more rural docs who have very diff scope of practice aren't included

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, September 12, 2018 10:07:10 AM
Last Modified:	Wednesday, September 12, 2018 6:25:03 PM
Time Spent:	08:17:53

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Makes sense

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

My personal experience is that many College-run courses are of lesser quality and little practical relevance. I therefore don't want to see College-led recertification having too much impact on choice of CME activity/provider. Differential learning styles should also continue to be acknowledged. While some activities may have better evidence than others, this may not be true of each individual, and the individual is likely to be the best judge of their learning style and meaningful CME/PDP activities.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Reviewing core medical practice statements should be mandatory. Many doctors are not up to date with the basic expectations of consent, informed consent, and prescribing.

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
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Last Modified: Thursday, September 06, 2018 7:07:57 PM
Time Spent: 00:24:52

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Some of the ideas are fairly jargon-heavy and I'm not sure what they would actually mean so hard to comment. I'm familiar with the current process and find it generally good. Peer Review is very valuable - we can discuss any issues of concern, which can be very useful in reflecting on and improving day-to-day practice. CME is also good. However I do find it hard to engage with the PDP, ie: to come up with things that I particularly want to improve on. General Practice is so broad that I could probably come up with a different list every day, and it is hard to come up with a meaningful list at any particular point in time. The Domains in my PDP I find confusing, eg: what does "professionalism" actually mean, and more to the point how do I relate my practice to it?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I'm not sure of the place of the PDP - I've forgotten what I written it in as soon as I've written it as I'm never sure what to write so just put something down

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I am cynical about the idea of continuous quality improvement, and "how do you see yourself improving this year..?". I think this risks the perfect becoming the enemy of the good. If I am doing something well why should I have to improve it. Surely being good is more important than being better than you were. Maybe we should be asked what do we think we don't do so well and would like to improve, if anything. Are we allowed to say not much? As long as we are good enough? Should be open to improving, but shouldn't be compulsory regardless of how good we already are.

Q4 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?

Not sure

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review. Though I realise this can be difficult for isolated doctors, there should be flexibility for those

Q6 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?

My current peer reveiw groups work well. One at our own (GP) Practice, and another of Aged Care/Rest Home and Palliative Drs that I also attend

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

see above, sorry about the rant, probably haven't answered the questions asked but felt that some of the things diverge from our reality and wanted to comment on that. It reminded me of the Early childhood education curriculum at that stage of my (parenting) life, which I found to be an opaque piece of work - and I'm only talking about the summary

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
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Time Spent:	00:04:34

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

very negative

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

these are onerous activities and should not be implemented.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes. working in an underserved area already, trying to take care of patients with less and less help from rmo's who work less and less, means far less time to jump through ever increasing level of recertification bureaucracy.

Q4 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?

none that i am aware of

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

internal at the very most.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

i don't believe in this.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, October 29, 2018 10:37:17 AM
Last Modified:	Monday, October 29, 2018 11:06:44 AM
Time Spent:	00:29:26

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Generally reasonable.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Flexibility is important -- there should be a range of options to match people's varying practice settings. Regarding increased emphasis on evidence: Do not be dismissive of less directly relevant components such as some academic activities. While they may or may not directly affect patient care, for some providers these activities stimulate an interest in their specialty and motivate a desire for self-improvement, both for the patients under their care and and for the intellectual challenge.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The challenge will be to be able to maximise professional competence while minimising the cost of administration to the provider's time.

Q4 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?

Not really. Electronic/online methods are highly desirable, and I expect all colleges have moved in this direction.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Peer review is part of my everyday work. As a radiologist I continually assess my colleagues when I review images for multidisciplinary meetings, and when I use a previous examination to compare with the current examination. In the modern computer-based environment, this audit data should be able to be used for re-certification with minimal effort by the provider.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

A logical approach is important. Evidence is important to validate an approach. But conversely a lack of evidence does not necessarily mean an approach is invalid -- the evidence needs to show it is invalid, and where evidence is lacking the approach may still be worthwhile.

Page 2: Submission information

Q8 Your information:

Name	**Mike Hurrell**
Company	**Canterbury District Health Board**
Email Address	[redacted]

Q9 Your position/title:

Consultant radiologist; Clinical senior lecturer (University)

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 17, 2018 1:00:24 PM
Last Modified: Monday, September 17, 2018 1:41:34 PM
Time Spent: 00:41:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

In my opinion the 6 core components are a reasonable framework and link in quite closely with those used by a number of the Medical Colleges however I still struggle to see how these really link to the work place front end core standards for: clinical competence, professionalism , ethics and communication. I think the missing ling is the employer and their role in recertification with built in quality assurance and quality improvement .

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Given my comments in Q1, I would like to suggest that Employers are required to invest in the recertification process and work closely with the MCNZ and Colleges. This might be quite unpopular amongst my colleagues, but I think the large sums of money the DHBs pay to SMOs for CPD activities is not used to support much of what the decertification document proposes , and is largely used to support conference/travel activities which make up a very small part of what is being proposed. However in saying this I also wouldn't want the money to between swallowed up by Employers (DHBs) and not ring fenced for recertification activities which the DHBs could/should be actively and assertively supporting

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I think the Colleges can only do so much, and given the diversity of the doctor's actual workplaces and career plans, there is no way the Colleges could possibly even start to be able to adequately manage /attend to many of the new proposals. Unfortunately the reality is now that employers are more focussed on jobs and filing positions to meet clinical need in the short term and less focussed on career planning and sustainability of their work force and hence recertification also becomes a short term means to an end and not what is being proposed which is a formative spiral of professional development. An example of this is that a doctor can do that might be referred to an audit ("snap shot"), but in fact never progresses this through an audit cycle. an audit cycle

Q4 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?

RPRs a a good idea, but haven't really taken off and my prediction is that only a very few are ever really done properly and lead to real change and this is because they are expensive and just aren't going to happen for most. An alternative would be for each SMO to have an appointed peer reviewer provided for by the employer (DHB) who uses a RPR framework and conducts a practice review on their peer at one point in the year, using local peers will be less threatening, and more cost efficient and easier to administrate. The employer might think to using retired, or semi retired colleagues of good standing and have a dedicated recertification administrator to manage the process (using some of the SMOs CPD money to do so)

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, as this would be at odds with the individualised process and proposal number 3.

Q6 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?

see my answer to Q4

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

As noted above employers (DHBs are integral in this, as recognised by the MCNZ in the prevocational training)

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 3:20:55 PM
Last Modified:	Friday, September 07, 2018 3:34:54 PM
Time Spent:	00:13:58

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They make sense. Especially actual sit-in practice reviews.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Profession-led is fine for content (which sits best with college), but not necessarily for attitudes and "culture". The RNZCGP had a good practice visit template years ago which included patient surveys and a visit by another GP. The MCNZ should specify who gets the 360 surveys and their contents.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The MCNZ should liaise with AMC in setting the process so that this is consistent across all colleges. There is a significant cost to practice visits. Granting at least 10 hours to both visitor and visitee would help. Also training for vistors would be needed (?online) and should be "paid for" with CME credits.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review and practice visits / review.

Q6 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?

We have a good arrangement currently. Fortnightly meetings. No RPR process.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

MCNZ / AMC doing a lot of work to specify RPR process and forms.

Page 2: Submission information

Q8 Your information:

Name	**Neil Jamieson**
Company	**CDHB**
Email Address	[redacted]

Q9 Your position/title:

Consultant Psychiatrist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
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Last Modified: Wednesday, October 31, 2018 10:51:11 AM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

all good except assuarance of cultural competence and learning about cultural competence are missing

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

as above - embed cultural competence assessment and learning into the activities

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

no

Q4 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?

nil

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

as above

Q6 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?

no issues

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, October 05, 2018 10:52:15 AM
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Time Spent:	00:08:10

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

All good in theory - the practicalities will be the issue

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The Colleges will have to take the lead here & that immediately raises the issue of what to do with Australasian colleges with 2 separate medical councils

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

A large piece of work - do the Colleges have the capacity to do this? PDPs are not something Drs are generally familiar with so plenty of training needed here. Who has the skills to sign off a PDP as being appropriate for the individual? Individuals may produce a PDP which doesn't focus on areas of weakness but instead on areas of "comfort" i.e. not focussing on areas for development just areas of interest.

Q4 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?

I'm not sure Colleges have the capacity and resources to do this work in a timely fashion.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

RPR is very resource intense and requires huge commitment by expert peers. How would this be funded and Drs time back-filled? Council will know from the costs & logistics for VPAs for just a few individuals that the costs will be enormous.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Mark Jeffery**
Company	**CDHB**
Email Address	[redacted]

Q9 Your position/title:

Medical Oncologist & CD Medical Capability Development

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, September 23, 2018 10:00:31 AM
Last Modified:	Sunday, September 23, 2018 10:13:49 AM
Time Spent:	00:13:18

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Key components proposed are reasonable but clearly more detail is needed. Some SMOs actively engage in CPD but some do not. Reflective practice is really important but it needs to be made easy to allow those that less engaged in CPD to do so without being punitive. NZMC will have to provide good resources to inform SMOs on how to fulfil certain areas of the recertification. I like the idea of differential weighting to various CPD activities because all CME activities are not equal!

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

As above, there needs to be comprehensive resources from the NZMC about how to achieve the key components. That may be an on-line format to allow SMOs to do MSF/360 degree feedback easily. Resources on how to do peer review well, how to set up a peer group etc.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Engagement will be the key challenge. Not all SMOs will engage in the recertification well. It should not be a "tick box" exercise or "just doing it because I have to" but it should be about reflection and improvement. Having rigid timelines i.e. a number of audits/year or MSF every x years may not be well received but looking at the overall picture of what a SMO does each year is important. For example an SMO may do a really comprehensive clinical audit over 2 years and that should be "counted" rather than requiring to do one clinical audit/year.

Q4 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?

Need to have good engagement with the medical college with discussion about how to integrate. Some colleges may already do recertification/CPD well and their innovations should be encouraged and spread across other colleges.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Some form of peer review should be mandatory but that could be participation in M&M meetings, review of SAC cases, peer review or peer groups etc.

Q6 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?

Already have good M&M and peer review in our department. As mentioned guidelines for how to do peer review well will be important.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Ensuring adequate communication about the proposed changes is important. That should not just be email (often ignored) but also meetings with SMOs in forums.

Page 2: Submission information

Q8 Your information:

Name	**Cheryl Johnson**
Company	**Waitemata DHB**
Email Address	[redacted]

Q9 Your position/title:

Clinical Director Geriatric Medicine

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:41:01 PM
Last Modified: Thursday, September 06, 2018 5:51:27 PM
Time Spent: 00:10:26

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

"In seeking to strengthen recertification programmes, the Council's primary focus is on the protection of the public" - protecting the public feels like such a weak goal, lacking in any aspiration towards excellence.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

College-led CPD seems the best model.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

need to align NZ and Australia demands on colleges

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CPR and communication skills

Q6 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?

practice review by colleagues

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**chris jones**
Company	**ccdhb**
Email Address	[redacted]

Q9 Your position/title:

specialist anaesthetist and pain medicine physician

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 9:59:06 PM
Last Modified:	Thursday, September 06, 2018 10:11:47 PM
Time Spent:	00:12:40

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It seems very similar to what we are required to do already

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I am a GP. I feel that these are already being done.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

RPR- what criteria are they judging their peers on? Who pays for their time?

Q4 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?

As for my previous answer

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review. CME

Q6 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?

We have peer review with GPs from nearby practices. This is after hours. We already work pretty hard - don't add in more stuff that we need to do in our own time. We have families and lives outside of work

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**Victoria jones**
Company	**Kakati medical centre**
Email Address	[redacted]

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: Brian Joondeph [redacted]
Sent: Friday, 7 September 2018 6:53 a.m.
To: Strategic Consultation
Subject: Fwd: MCNZ - Strengthening recertification - discussion document for feedback

Categories: Blue Category

I think recertification in some form is a good idea.

From my perspective, I spend most of my practice time in the US. I participate in a Maintenance of Certification program through my specialty, the American Board of Ophthalmology.

I appreciate the MCNZ allowing this program to suffice for my recertification requirements for NZ.

Consideration should be given for alternative recertification programs outside of NZ if they are reasonable, such as the American specialty boards or similar.

The larger issue is whether the MOC programs are meaningful in terms of maintaining competence in one's specialty or just busy work with a high fee attached to it? There is much controversy in the US over some of these MOC programs for this reason. Ophthalmology is pretty good. There is self study and assessments as part of the program.

Other specialties such as internal medicine, have had challenges in coming up with a reasonable program.

Unfortunately these programs test medical knowledge, but not equally, if not more important, issues such as ethics, judgement, interpersonal relationships, etc.

Thanks for allowing me to comment.

Brian Joondeph, MD
[redacted]

Begin forwarded message:

From: Medical Council of New Zealand <sconsultation@mcnz.org.nz>
Subject: MCNZ - Strengthening recertification - discussion document for feedback
Date: September 5, 2018 at 10:18:18 PM MDT
To: joonbug@mac.com
Reply-To: Medical Council of New Zealand <sconsultation@mcnz.org.nz>

[redacted]

From: Brian Joondeph [redacted]
Sent: Thursday, 1 November 2018 11:18 a.m.
To: Strategic Consultation
Subject: Re: MCNZ - Strengthening recertification for vocationally-registered doctors

Comments if you want some. I am MCNZ [redacted]

My perspective is as a mainly US based eye surgeon spending a few weeks per year working in NZ. Years ago I was a full time consultant in Auckland.

We have a recertification program in the American Board of Ophthalmology. It is mandatory for younger doctors. I am older and grandfathered as a time unlimited certificate. But as an examiner for the Board they want us to go through the recertification process which I did. An every 1o year process.

It is reasonable but doesn't inform as to whether I am meeting the standards of my peers. That is difficult to assess.

What tells me I am competent are the following, although I don't know how well they can be formalized into a recertification program.

I practice in a group of 12 retina surgeons. We see each others patients, operate on each others patients. It is quickly and obviously apparent if someone is not competent.

We participate in clinical research, mainly FDA registration trials. I am a principal investigator for many of these studies. That keeps me at the cutting edge of research and development of the next generation of drugs.

I attend various society meetings. Watching presentations, especially case presentations, and chatting with colleagues, I find benefit in knowing I have a similar approach to situations that my peers do. That's the biggest benefit to these meetings, knowing that I am in the mainstream, or may already be doing what someone is presenting as new or innovative.

Reading journals. Keeping up with new studies, data, practice guidelines, etc.

The American Academy of Ophthalmology Iris registry captures our data in almost real time. The government in the US and insurance payers are monitoring our outcomes. This can be helpful as well to know that I am not an outlier, although it doesn't factor in case selections, more difficult cases, etc.

I can spend a few hours with a peer, watching how they perform in clinic or operating, and have a good idea if they are practicing at an appropriate level versus being incompetent or dangerous. But logistically it is difficult to have every clinician observed on a periodic basis.

Your latest document is making good progress and I commend you for being proactive.

My experience, at least in my specialty, is that my ophthalmology colleagues at ADHB are well trained and competent. The quality of training in NZ is excellent and at least in the public hospital eye clinic, it would become apparent quickly if a consultant was not meeting the standard.

Hope my comments are helpful. Reach out if you have any questions or feedback.

[redacted]

Collector:	Web Link 1 (Web Link)
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

principally they are good but the devil will be in the details

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I suggest a wide array of methods and possibilities as physicians have such varied job prescriptions, are in different stages of their careers and not all setting will lend themselves to all required activities

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

there will always be special circumstances and any program should make allowance for it or have a process on how to make it work for those physicians -e.g. there are part time physicians, physicians that only do locum work, physicians at the beginning, mid and end of career, working in combination settings, etc.

Q4 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?

offer multiple avenues for each category such as on-line module, in-person attendance of conferences, liaise with other colleges/certification programs in other countries

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no, but there should be some highly recommended such as opioid prescribing, cultural sensitivity, recognizing abuse, dealing with end of life situations

Q6 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?

morbidity and mortality conferences, division and departmental meetings with specific goal of peer review, standardized on-line courses/tutorials

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

consider revising the audit requirement - it is difficult for part time physicians, locum physicians to comply with that regulation. Consider reducing the frequency or finding an alternative on-line activity to make it possible for physicians who don't have a long term contract

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 6:54:28 AM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Concerns about duplications

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

All good suggestions. How are you going to rigourously monitor?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time to carry out audits etc. most Drs probably have to be taught of how to do an audit. Will MCNZ provide this training?

Q4 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?

Time consuming. Needs to be an app on your phone with a regular reminder to enter activitied

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Most doctors are enrolled in a program that requires them to fulfill quality assrance. So why repeat?

Q6 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?

Annual performance review using a template from the MCNZ instead of a DHB one. So no duplication

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Trial first on a few and refine before rolling out

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, September 09, 2018 8:33:38 PM
Last Modified: Sunday, September 09, 2018 8:41:44 PM
Time Spent: 00:08:06

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

not happy at all

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

simplifying the programme

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

more costs will be imposed on practices as well as more bureaucacy increasing risk of burnout

Q4 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?

Practice review -scrap this. Why do this twice in the form of Cornerstone and now through the recertification programme - simplify it!

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review

Q6 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?

is RPR regular practice review? If so I do not want this as an option as this is being done in the form of peer review and accreditation

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

SImplify, simplify simplify.....do not add more bureaucacy to busy GPs' lives!

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, September 11, 2018 10:55:24 AM
Last Modified:	Tuesday, September 11, 2018 11:04:45 AM
Time Spent:	00:09:21

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Where is the evidence that change is needed? The council is resonsible for public safety - does the council feel that this is significantly at risk? Secondly the "evidence" of the effectiveness of the proposed changes is based on published material that is largely not published research but reviews of literature. This is not supportable. Furthermore 60% of even published medical research turns out to be not reproducible so you are really on thin ice claiming there is evidence to support the proposed changes. Your review of literature needs not to look at reviews but go back to the original papers, analyse each for scientific merit and see if the research has been verified by further studies. This is a lot of work but it is the only way that you can claim to have done it properly.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I don't as I don't accept they are based on good science.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 11:42:42 AM
Last Modified:	Wednesday, October 31, 2018 11:59:08 AM
Time Spent:	00:16:26

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Reasonable

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

First verify that the respective colleges have not already done so.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

More - and worse - redundant work, as the ANZCA appears to have already implemented an up to date CPD curriculum along the lines of your proposal.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Human Factor in Crisis Management

Q6 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?

Peer review by a colleague

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

More online options to accomplish key CPD requirements

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 28, 2018 10:59:17 AM
Last Modified:	Friday, September 28, 2018 11:02:50 AM
Time Spent:	00:03:32

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Sounds good

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think the GP college already has a relevant programme

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The difficulty for the college's of working out what is evidence based CPD in their area. My be lots of evidence for some college's but not for others

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Regular review in place of work by external source

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 17, 2018 1:48:56 PM
Last Modified: Monday, September 17, 2018 3:31:53 PM
Time Spent: 01:42:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Overall the concept is good. However, a minimal of one audit per year, in addition to other CPD (continued Professional Development) requirement, appears burdensome and impractical. There are now increasing evidence that quality and not quantity that the medical profession should be aiming for, so that the academic activities will be robust and not just a box ticking exercise. In my view, an audit every 3 years which is formally presented to the department/hospital/medical conference/medical meeting etc is probably more practical and effective.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Through liaison with the various specialist colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time and resource constraint - if more time is invested in CPD activities, less time is available for clinical work.

Q4 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?

No opinion

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Emergent cares ie advanced life support, safe use of defibrillator etc

Q6 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?

No comment

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No other comments

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:05:12 PM
Last Modified: Thursday, September 06, 2018 9:23:52 PM
Time Spent: 00:18:39

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

"Value-based" instead of time based has potential to be subjective and bureaucratic.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Please DO NOT make RPR compulsory, we just can't afford it.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I note the emphasis on employers supporting CME. This is little consolation to the self-employed.

Q4 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?

Increasingly proscriptive programmes will increase difficulty of implementation and follow-up.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

ACLS for anyone in clinical work. Beyond that please no. It becomes a feeding frenzy for vested interests.

Q6 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?

Happy with current RNZCGP and RNACUC peer group system. Mutual support/learning is nest achieved without too many constraints. RPR is costly and not viable unless Govt/Medical Council funds it.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Frankly this is a slap in the face when I am vocationally registered in General Practice, and near qualifying in Urgent Care, both disciplines in which any doctor can work as a general registrant, and there is minimal recognition of my training.

Page 2: Submission information

Q8 Your information:

Name	**Christine Laws**
Company	**Silverdale Medical**
Email Address	[redacted]

Q9 Your position/title:

GP partner/Urgent care trainee

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Wednesday, 31 October 2018 9:22 a.m.
To: Strategic Consultation
Subject: NZMC discussion document re: recertification

Dear Carol,

I have read the NZMC discussion document regarding recertification. I noted the use of multiple undefined acronyms. While I can make assumptions as to what these are likely to be, in the interests of clarity and good communication I suggest you define each one.
For example, MSF = Medicins Sans Frontiers and RPR = rapid plasma regain, but presumably this is not what you are meaning here?

Yours sincerely,

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 1:01:09 PM
Last Modified: Friday, September 07, 2018 1:11:17 PM
Time Spent: 00:10:08

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Nice ideals. There are a small proportion of doctors at the lower centile that are the potential problems. This proces will not address this group

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Peer review and an overal Chief medical officer for a group of doctors has teh potential to work the best

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. Box ticking is easy. I can do that in front of the TV. Doesn;t mean I am up to dte and competent

Q4 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?

These are well set up and seem to provide some framework. Bit difficult to get useful onformation out to avoid a rogue doctor

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Participation in peer review meetings. Sitting and talking with colleagues ensures those outside the boundaries of competence will become evident. Its also collegial.

Q6 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?

see Q5

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

You are going yo do it anyway.. why don't you ask teh UK? And see what their expereince is rather than er invent teh wheel. They have been at it for a decade

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 8:25:53 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Monday, 10 December 2018 8:44 a.m.
To: Strategic Consultation
Subject: Recertification

Categories: Blue Category

Have been part of UK revalidation for 2 5 year cycles

Main problem is that it tends to repeat appraisal – if appraisal is robust then Recertification adds nothing and is just a wasteful assurance program. This is especially the case if Recertification is devolved to local Medical Directors or equivalent.

Appraisal and Recertification would need to be clearly demarcated otherwise Recertifcation is a repeat of appraisal with messy overlap.

It would be better to make Appraisal more robust eg appraise cannot choose at least one appraiser, appraisal to include challenge, appraisal to have summary and developmental components, appraisals to include performance information as well as reflection, career development etc

[redacted]

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 9:18:25 AM
Last Modified:	Wednesday, October 31, 2018 9:27:00 AM
Time Spent:	00:08:34

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Evidence that change is necessary is weak

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

make them practical and provide very specific examples rather than aspirational gobble-gook terms. Any requirements need to consider both time and money. I do not have time to do many of the vaguely described things proposed. I don't have time to eat lunch and current contracted non-clinical time is non existent and an aspirational inside joke for managment. My DHB lacks the resources to evaluate my practice - no data is collected

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time, money, and data

Q4 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?

Please pay attention to the smaller DHBs who have a single sub-specialistt in a many disciplines. How to I get peer review?

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Reading

Q6 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?

I really do not see how the RPR would be done in my current DHB environment. We do not have the time or the tools to do it. The council has to provide very specific examples and publish tools for this to be accomplished, or you will just create a paper program with little value

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

1) Don't ignore the smaller DHBs as is usually done, 2) provide very specific examples of proposals, 3) Publish tools and resources to accomplish requirements, 4) Mandate that DHBs provide time, money and practice data in order to accomplish the requirements. 5) Hopefully the age discrimination in the original proposals has been eliminated, both in writing and spirit.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 7:21:22 PM
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Time Spent: 00:15:56

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

In principle agree

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

My proposal is to have local annual appraisal system in place. We can adapt to annual appraisal systems used in different hospitals/trusts in UK.It looks at individual's actual work load, clinical activities undertaken, complaints, death rates/complication rates, CME activities ,compilation rates/mortality figures etc. It is formative and done by a trained Appraiser. In Scotland the NHS Education for Scotland runs the courses for the appraisers.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Lots of challenges at ASMS & DHB levels. They need to provide extra resources.

Q4 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?

Please use the experience of NHS in UK

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME, MSF and patient feedback. Last 2 are 3 yearly intervals

Q6 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?

RPR would need assessors from different DHB's. Who will pay for their time and who will cover their clinical work when they are doing RPR. It will affect on work force planning, job sizing, training of people undertaking RPR. Would RPR be local or national? Some colleagues would not want/like their RPR to be done by their own colleagues. Interpersonal issues

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

As above

Page 2: Submission information

Q8 Your information:

Name	**Dr I H Malik**
Company	**Houra Tairawhiti (Tairawhiti DHB)**
Email Address	[redacted]

Q9 Your position/title:

Consultant Physician

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
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Time Spent: 00:34:01

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

to make sure that reigistered doctors are aligned with Council's requirements, maintaining high stardard of care to their patients and up to date with latest medical knowledge.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

To strengthen most relevant and valuable activties for scope of practice. Example, CME related to particular specialty in stead of generic activity, regualr peer review, audits, relevant conferences or workshops and participation in teaching prgrammes

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I do not foresee any major challenges.

Q4 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?

I do not foresee any major concerns.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Current recertifcation CPD requirement is comprehensive and that covers many areas that we need to practice and learn. However, mandatory attendence to at least one conference or workshop per year particaularly relevant to vocatianal scope of practice shold be implemented. Conferences usually are the major source of sharing and learining in latest advancement in medical field/manamgement.

Q6 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?

No.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No other comments

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
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Last Modified: Tuesday, September 11, 2018 1:25:39 PM
Time Spent: 00:11:45

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I thought the key components were well thought out and supported.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Look to existing professional bodies to define the key components for each vocation

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes, resistance to change and enforcement

Q4 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?

At least in Auckland there is regional interest in sub-vocational certification/re-certification in cancer patient care. For example, vocational certificaiton in general surgery with subspecialty certificaiton in colorectal cancer; or vocational registration in otorhinolaryngology with subspeciality certificaiton in H&N Cancer; etc.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

ACLS

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

MCNZ oversight is a good idea with engagement of existing regional professional bodies.

Page 2: Submission information

Q8 Your information:

Name	**Jon Mathy**
Company	**CMDHB**
Email Address	[redacted]

Q9 Your position/title:

CMDHB CD Cancer Services

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Allowance should be made for length of experience, with lower hours expected for older doctors

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Less peer group hours expectation. more readily available CME opportunities, self learning activities more clearly expressed.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Resistance to any attempts to increase the hours of MOPS/CME given the increasing hours worked and lower numbers of doctors coming into the GP workforce

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Major CME sessions. Peer Group participation but at a reduced level

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 13, 2018 10:30:15 AM
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Time Spent:	00:21:05

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The diagram on page 10 is a concise summary, and encapsulates existing elements. So the proposed strengthened approach is not dramatically different, and for me would be a natural progression.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The regular practice review needs work - to make it financially feasible (no additional cost), administratively more simple, less constrained, fitting for the actual work setting of the practitioner. Professional development plans - will require the 'line reports' of practitioners to be skilled in guiding the creation of the PDPs. Multisource feedback also needs to be fitting for the doctor's actual work setting.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The challenges will be with the more seasoned doctors who might already be ruing the loss of independent self regulating CME activities. This cohort of doctors characteristically can be entrenched and influential in a less than helpful way, for younger colleagues. Addtional challenge will be the inevitable electronic recording of activities and the teething issues - fitting square pegs into round holes.

Q4 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?

Medical Colleges have members from diverse settings, and don't easily flex to their needs/settings. Suggestion - creating core requirements, flexing the rest, timely responsiveness to members' feedback

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

regular practice review - in a simpler form than it is now - so that it becomes expected and valued by the doctor whose practice is being reviewed

Q6 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?

Peer review meetings work best - wide practice variation despite guidance available - wide variation in integrity and process and membership - such that the day-to-day working team meets and calls it a peer review meeting. Multiprofessional or multidisciplinary peer review adds rigour. Greater guidance from colleges ideal. Biggest barriers to RPR are the costs - financial and temporal and burden of preparation. Mentioned earlier.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The process outlined is as reasonable as can be.

Page 2: Submission information

Q8 Your information:

Name	**Carol McAllum**
Company	**Auckland District Health Board**
Email Address	[redacted]

Q9 Your position/title:

Strategic clinical director - integrated palliative care

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Valid topics for consideration.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The process should be assessing the general goals in the specific context of each College's current program. MCNZ could then require any NZ doctors not already aligned with a College through membership to choose a College and comply with its requirements.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Increased work and confusion generated by diverging parallel pathways of MCNZ and Colleges without corresponding benefit.

Q4 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?

Unknown.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Only College compliance or the equivalent for non-College members.

Q6 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?

Morbidity and mortality meetings, annual reviews.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

A patient centered focus on quality of care still needs limits because increasing non-direct care demands on doctors will eventually result in less time for care and alienation.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 10:45:25 PM
Last Modified: Thursday, September 06, 2018 11:05:37 PM
Time Spent: 00:20:12

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It follows the NHS/UK approach too closely - need for an NZ approach and rethink.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Problem is G Doctors are expert in 'gaming the system', therefore the more complex the system the easier to game. Making the activities and measures logical and easy to achieve will reduce the gaming. It also needs to address the wide varieties of work styles. I have found in the UK that as a casual GP working in Out of Hours only for 1-2 months each year the system is geared to full-time GPs and is very difficult for me to achieve. It takes me much more effort and work to complete my appraisal documentation each year. This is also true of the many locum GPs in the UK that work in several practices or have special interest work e.g. skin clinics.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Resistance from the participants is the greatest. Unless doctors see the point in completing recertification and are on-board with the process, they will see it as bureaucratic intrusion an do as little as they can to achieve the required hoops to jump through. It also needs to suit the variety of learning styles - not every doctor is a self-directed learner who enjoys goal setting, but this is the major default option. Also work with colleagues should be valued and included as learning activities e.g. college committees that deal with clinical issues, practice assessment and other exam activities, informal corridor discussion with peers and specialist colleagues. These are not always easy to document or prove, but are the most valuable learning experiences. Audit activities are the most difficult for locums and part-time doctors - FT GPs for example, can access audit activities easily via their software systems and ask their practice manage to come up with audit data. Much harder to do as a casual GP.

Q4 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?

Promoting meaningful audit activities that are not onerous or difficult to manage.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review. However this should include collegial activities as noted in Q3. Audit activities are useful but can be onerous for those not working in a regular practice or in a poorly organised hospital. Audit activities performed and promoted by the NPS in Australia are really helpful. Pharmac could provide a similar service on prescribing audits and path labs could easily send data on lab results set against aggregated data of peers.

Q6 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 above, collegial activities. However practice-based peer group meetings are valuable and most GP enjoy those.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

More consultation with a wider range of doctors in NZ. Make sure you get it right and keep adapting. This has not happened in the UK.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Thursday, 6 September 2018 10:56 p.m.
To: Strategic Consultation
Subject: Thoughts on recertification
Attachments: NPS AuditUrine MCS Testing.pdf; NPS Audit COPD.pdf

Categories: Blue Category

Hi Carol,
I am a semi-retired GP, NZ grad, who did a Family Medicine residency in Canada 1973/4 and after 3 years in GP practice there returned to work 20 years as a rural GP in NZ before moving to Australia to an academic job in a new school of medicine and as a GP trainer. During this time I completed fellowships in Canada (CCFP) NZ, Australia (ACRRM and RACGP) and the UK (JCPTGP) that was followed by a year working in the UK and Ireland 2004/05 followed by annual visits to the UK each year since for 1 to 2 months during which time I have worked sessions in Out of Hours GP every year till 2017. Therefore I have completed reappraisal in the UK every year since 2005, when I was in the first cohort appraised, including 2017 when I completed my last appraisal. I was active in the RNZCGP as an examiner up to 1997 when I moved to Australia and was initially very active with the RACGP, organising 6 annual conferences in north Queensland, but later became more active with ACRRM and remain a senior examiner for all components of the fellowship including MiniCEX (which involves practice visits) and as a PESCI (Pre-employment Structured Clinical Interview) panel chair interviewing IMGs (International Medical Graduates) seeking the right to practice in Australia. Since 2009, I have been doing occasional GP locums in NZ, and for the past 3 years casual sessions in Urgent Care.

I know that is an awful ramble but I thought relevant to establish that I do have experience of clinical practice in 3 countries (not including Canada and Ireland!) and extensive experience in medical education and recertification activities.

My concern with the proposed MCNZ plan is that it draws too heavily on the experience in the UK. I know it is an NZ tendency to idolise the NHS and see it as the gold standard, but be assured the view from the UK is somewhat different. It is not a system that suits NZ well. The weaknesses of the Re-appriasal system are that it is too structured - there is only one way to do your appraisal and the process of entering data on the web clumsy and frustrating. The system is aimed to find Dr Harold Shipman and my UK colleagues say it would never have caught him as he would have been helping to design the system. Complex systems with absolute requirements encourage gaming and most GPs here seem to game the system. The one valuable part of the process in the UK is the visit to an appraiser who is a GP colleague and the discussion is useful if one is open and honest and wants to hear the feedback. That one is limited to only 3 annual appraisals with the same appraiser is a bit frustrating as I think the long-term relationship would be useful and collusion could be avoided. I especially enjoyed the appraisal visit as my on-line appraisal document each year was very different from regular GPs here - both the scope and experience of practice and the degree of care I am able to provide patients are a rural GP. I enjoy seeing their reaction and having their comments about what I do. I also enjoy the chance to have an independent colleague review what I do and tell me of any areas for improvement and reassure me, as I age, that I am still competent and OK to continue in practice.

Audit activities for Re-accreditation in the UK are very difficult for casual GPs like me as the system is geared to fulltime GPs in a regular practice where the audit activities can be performed easily by the practice manager using the practice computer software. This is much harder for locums and casuals like me. I also find the activities do little to stimulate reflection. Audit activity is loved by education researchers as it meets all the criteria for self-directed learning, is easy to validate and assess, but that does not make audit useful - just something GPs endure and do in order to meet requirements. The same goes for patient satisfaction surveys and MSF feedback - I have done 3 or 4 DISQ and 2 CFEP surveys and feel I learned little about myself and do not think it lead to changes.

The NPS in Australia, while an irritating organisation, does provide some unsolicited audit material on prescribing and does have some useful audit activities one can enrol to do and I think that would be a good model to follow. I attach a typical report from NPS. Pharmac could be required to provide similar audit data as could path labs. These would be useful audits and clinicians could then reflect on the results for their recertification.

Peer group activities are useful and valid, but the definition of what is a peer review activity needs to be broad. For me, the meetings I go to of other GPs in Urgent Care once a month are of little or no benefit but they do get me the all important points. The much more valuable peer activities are discussing patients in the corridor or consult room with

colleagues, phone calls to specialists for advice etc. These are not easy to document, but are workplace based and most valid. Even more useful is the peer activity I get as a senior examiner for ACRRM (and did as an RNZCGP examiner up to 1997) where the clinical discussion continues for the full 2 days of the exams. Similarly PESCI panels provide excellent peer review as the 3 panelists discuss applicant performance and their own clinical cases and work. I have included these in re-appraisal as activities but feel they are not given the credit they deserve and the RNZCGP gives them scant regard.

Above all, the need to make the process easy for doctors to engage with and not bureaucratic or inflexible is the highest priority if the process is to be valid and have genuine value. As I noted earlier, doctors are experts at gaming the system. Making the system rigid as happens in the UK is bound to fail. Better to make it an enjoyable and flexible process that have value for the clinicians themselves, and ensure it is fair and feels fair.

Hope this helps. Would be happy to be involved in a committee or whatever to contribute my views if it helps.

Cheers,
Andrew

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:21:57 AM
Last Modified: Friday, September 07, 2018 9:37:18 AM
Time Spent: 00:15:21

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

providing there is though given to context I think they could be appropriate

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

the colleges should have a strong guiding influence and direction on structure

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

if the burden of administration is placed on the individual with enormous time constraints we already have this will add to them

Q4 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?

it would be around their knowledge of specific contexts. We have to get away from didactic teaching and learning and work to creating a more collegiate culture of learning and discussion

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

caring for yourself

Q6 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?

peer review should be contextual for the workplace

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

do not make it too cumbersome to complete

Page 2: Submission information

Q8 Your information:

Name	**David McLeod Hill**
Company	**Health Hub Project**
Email Address	[redacted]

Q9 Your position/title:

medical director

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, November 04, 2018 3:13:45 PM
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Time Spent:	00:04:01

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

meaningful MSF needs to be compulsory

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

meaningful MSF needs to be compulsory

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

time , support

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

meaningful MSF needs to be compulsory

Q6 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?

cost / time

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector:	Web Link 1 (Web Link)
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Time Spent:	00:18:08

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

generally positive

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

RPR by the Council, particular for those of us in solo private practice

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

it would be hard to get 360 feedback and collect data in solo private practice

Q4 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?

I think the RPR with the Colleges providing and perhaps expanding. The cost is a concern for a solo practitioner

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

regular review of the international literature is essential

Q6 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?

when in solo private practice in an area where there are few colleagues to form a peer review group, this can be a big problem.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I think it is good that this matter is being reviewed and the approach the Council is taking

Page 2: Submission information

Q8 Your information:

[redacted]

Q9 Your position/title:

Dr

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

COMPLETE

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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree. I particularly Item 2 with the emphasis on the value of activities is important. Also point 4, and the council encouraging colleges to enhance this with online tools for doctors.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

More support for personal audit. Audit ideas, sample audit to lower the difficult barrier to doing personal audit.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Regular Practice Review (if that is the BPAC one) is quite time intensive for the day it occurs, but does not happen very often.

Q4 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?

Sometimes being too generic

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

multi-source feedback, not necessary every year, but every 3 years at a minimum

Q6 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?

multi-source feedback, discussion of readmission, death, procedural complication data. Mortality & morbidity meeting.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Speaking from a hospital doctor perspective, perhaps DHBs shoudl keep a register of peer-review and support groups, and encourage doctors to join one.

Page 2: Submission information

Q8 Your information:

Name	**Oliver Menzies**
Company	**ADHB**
Email Address	[redacted]

Q9 Your position/title:

Geriatrician & General Physician

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 11, 2018 3:09:58 PM
Last Modified: Tuesday, September 11, 2018 4:09:41 PM
Time Spent: 00:59:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

certainly flexibility is needed. What is required at the start of a career is different to someone who has been involved for many years

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

an interactive approach would be good.time is what most professionals lack and to create something from scratch is stress creating.to be able to respond to something already produced would be very helpful.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

challenges arise when something is complicated. keep it simple and it will be easily implemented

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. personnally i have always found attending education events and mixing with others in my field by far the most valuable experience. being involved in teaching is also valuable as it makes you look at how you practice. I think keeping it simple is the best way forward, don't add stress to and already under seige profession.

Q6 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?

the biggest difficulty is getting people together.call on time is always resented and very difficult to coordinate.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

making it relevent to the age and stage of the individual is important

Page 2: Submission information

Q8 Your information:

Name	**valerie miller**
Company	**wakatipu medical centre**
Email Address	[redacted]

Q9 Your position/title:

senior partner/ GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, November 04, 2018 9:32:06 PM
Last Modified:	Sunday, November 04, 2018 10:25:15 PM
Time Spent:	00:53:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Seems sensible - however should minimise compliance burden on practitioners.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

CME activity should reflect areas already highlighted in PDP

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

If increasing compliance my have unintended effect of encouraging people to retire too early

Q4 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?

Happy yo leave it to the colleges but MCNZ should play a moderating role to ensure hat there are no outliers from College perspective in terms of requirements should be similar across colleges.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

PDP, RPR, Patient & colleague/staff feedback

Q6 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?

I think this is important

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: Laurie Jo Moore [redacted]
Sent: Thursday, 1 November 2018 11:33 a.m.
To: Strategic Consultation
Subject: RE: MCNZ - Strengthening recertification for vocationally-registered doctors

Dear Officials of the Medical Council of New Zealand,
Thank you for the offer to contribute.
I was recently working at the Loma Linda medical school which is one of the top 5 medical facilities in the US. I was teaching residents in psychiatry. I found that most residents were not in touch with their own suffering and therefore unable to be present for the suffering of their patients. I proposed a course to address this but my path took me somewhere else. I don't know what has happened to doctors in America or to trainees. One difficult problem is that they all end up having a debt of almost half a million dollars by the time they finish training. This would be a terrible burden to carry for young people getting married and starting families.

I bring this issue to your attention because I know that most credentialing activities are focused on information and whether or not the doctor has stayed current with the standards of practice. I understand this and it is needed. However, whether or not a doctor is able to help any one particular patient really depends on something other than their clinical knowledge. It depends on their capacity to be present and to open their own heart.

I imagine you have all experienced going to doctors who don't listen to you and don't seem to care about what you are trying to tell them.
This is either the beginning or the end of helping someone.

I suppose a doctor could choose to be assessed for this capacity perhaps by conducting an interview and watching it with someone who is both compassionate and knowledgeable about empathy and attachment. I think it would be better to give doctors a choice to volunteer for this because it could be threatening for them. If there was some merit attached to participating in this process, that would make it something desirable. I would see this process more as something to help doctors than as a way of reprimanding them. We all need to learn how to listen to each other and connect with each other to make this a better world.

Kind regards,
Dr Laurie Jo Moore

From: Medical Council of New Zealand <sconsultation@mcnz.org.nz>
Sent: Wednesday, October 31, 2018 9:00 AM
[redacted]
Subject: MCNZ - Strengthening recertification for vocationally-registered doctors

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, October 19, 2018 8:03:28 PM
Last Modified: Friday, October 19, 2018 8:13:43 PM
Time Spent: 00:10:14

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It all seems like overkill - making what should be a reasonably straight forward process unnecessarily complicated - it will cause a considerable amount of anxiety if implemented for very little practical gain!!!!

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Leave it to the individual colleges to decide what they require for recertification

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes - you will struggle to get buy in from front line practitioners - this see,ms be an academic process dreamed up by a committee will very little day to day clinical exposure. It's hard enough working in DHBs currently without having "strenghtened" recertification measure inflicted on us. Alot of the suggested measutre atre not practical - particularly in smaller centres.

Q4 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?

No - this is poorly thought out and very impractical

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Yes - it will involve / waste a huger amount of manpower and chew up what are already very scarce health resources

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

You can't implement something that is so fundamentally flawed and poorl;y thought out.

Page 2: Submission information

Q8 Your information:

Name	**Mr G Morrissey**
Company	**Hutt Valley DHB**
Email Address	[redacted]

Q9 Your position/title:

Surgeon

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 08, 2018 9:18:28 AM
Last Modified: Saturday, September 08, 2018 9:31:44 AM
Time Spent: 00:13:16

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Leave it to the colleges

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Liaison with professional colleges CPD programmes to ensure clinical professionala eductaional administrative and research domains

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No

Q4 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?

ACEM have a great model

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes

Q6 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?

Again refer to ACEM for guidance

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

none

Page 2: Submission information

Q8 Your information:

Name	**Andrew Munro**
Company	**NMDHB**
Email Address	[redacted]

Q9 Your position/title:

CD ED Nelson Emergency Department

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, October 11, 2018 2:22:18 PM
Last Modified: Thursday, October 11, 2018 2:30:58 PM
Time Spent: 00:08:40
[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Should be done through College in conjunction with specialyt society as part of CPD. Shoudl eb on-line modules not face to face or courses that are time consuming, Shoudl be tied in with the ausit programs we all participate in

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Audit, completing on-line modules on clinical and non-clincal subjects

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Not sure what the proposed approach is

Q4 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?

Not if done through college

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Audit participation

Q6 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?

??

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, October 12, 2018 10:10:14 AM
Last Modified:	Friday, October 12, 2018 10:42:21 AM
Time Spent:	00:32:07

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I write these comments as someone who was involved the GMC's pilot studies on revalidation of doctors back in 2004 while working with the Peninsula Medical School at Exeter University in the UK. I was a statistical consultant on a pilot study on doctor revalidation funded by the GMC which has since led to compulsory 5 year revalidation in the UK of all 200,000 doctors there. I have also been involved more recently in reserach on patient, colleague and self-evaluation data for the recently published Medical Board of Australia's Professional Performance Framework for all 100,000 Australian doctors. It is on the basis of my past experience as a statistical researcher that I make the following comments. The MCNZ recertification proposal, in my view, does not distinguish keeping doctors up to date, which could be a college or specialism responsibility, with ensuring their continued fitness to practice, which is an MCNZ responsibility. Similar recertification, revalidation and reaccreditation programs internationally acknowledge the need for medical councils and associated boards which have a legal obligation to ensure doctor fitness to practice to provide the public and policy makers including funders with assurance that they are effectively discharging their obligations, irrespective of what colleges do in terms of continued professional development. The current MCNZ document may need to focus on its own obligations more, in line with international standards and trends, rather than on CPD programmes offered by colleges. In particular, the MCNZ may need to draft processes, procedures and protocols which lead it to reach a summative and regular judgement on every registered doctor's fitness to practice. The current proposal does not acknowledge this Council responsibility explicitly and therefore is ambiguous as to what its responsibilities are in relation to colleges and to the public. So I believe that the document is lacking content in a key component of recertification, which is the need to ensure a doctor's continued fitness to practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

So far, patient questionnaires and colleague questionnaires are being used internationally as key components to gather prima facie evidence of continued fitness to practice of individual doctors, with colleague questionnaires supplemented with self-evaluation questionnaires being used to self-identify areas for improvement, leading to PDP in discussion with mentors from colleges or the workplace. These implementation methods should be formally described in MCNZ protocols and procedures to be followed on a regular basis (say, every three years or five years).

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Challenges include the sheer diversity of doctors' professional activities and the need to reach a summative judgement on a doctor's continued fitness to practice in the face of this diversity. However, international research indicates that there are common professional dimensions to every doctor's work. From the patient perspective, common aspects include warmth of greeting, explanations, reassurance, respect shown, amount of time, cultural sensitivity and involvement in treatment plans. From a colleague's perspective, common aspects are clinical knowledge and ability, communication with patients and colleagues, teaching and training colleagues, reliability, awareness of limitations, use of resources, team orientation, appearance and behaviour, and trustworthiness. Such common aspects are common to all specialisms and can form the basis of fitness to practice judgements on a regular basis. Another challenge I found when presenting talks on behalf of the GMC to various Royal Colleges was resistance by Colleges to the idea that the GMC could undertake regular evaluation of clinical competence in the all the specialisms and the lack of suitability of some of the methods for patients in some specialist areas (e.g. psychiatry, anaesthesia). The GMC's response to these arguments was to place much more emphasis on colleague feedback while maintaining overall responsibility for continued fitness to practice.

Q4 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?

The system recently introduced by the Medical Board of Australia (MBA) Professional Performance Framework (PPF) provides a useful set of guidelines that could also form part of the recertification process in New Zealand. The MBA, after considering issues of revalidation, has issued its latest version of the PPF for strengthening continuing professional development for its 100,000 or so registered medical practitioners. One of the core features of the MBA's PPF is the allocation of minimum CPD requirements across three types of activity: educational activity to develop knowledge and skills; activities focused on reviewing performance; and activities on measuring outcomes. Activities focused on reviewing performance may include peer review of performance, performance appraisal, peer review of medical records, peer discussion of cases, peer review of journal articles and peer review of educational activities. One other key performance review activity is multisource feedback (MSF) from peers, medical colleagues, co-workers, patients and other health practitioners. There is no indication in the current MCNZI Discussion Document of whether the MBA's approach has been investigated. The initial impetus for ensuring regular doctor competence evaluation/assessment in the UK (and then subsequently elsewhere) arose from the Shipman case, with subsequent investigations revealing that there had been concerns raised by patients and colleagues of Shipman over many years that had not been acted on in a systematic manner by the UK GMC. The GMC therefore faced a political thrust to ensure that it had robust, internal mechanisms in place to take into account patient and colleague feedback as well as well as other mechanisms for ensuring that doctors still had the clinical competence for fitness to practice. The implicit threat from the UK Government at that time was that if the GMC could not put in place robust, peer review measures, then externally imposed measures would be enforced through legislation. So another concern is that if MCNZ cannot show that its proposed and internal recertification process is fit for purpose to prevent a recurrence of Shipman, there could be a political decision to move responsibility for ensuring fitness to practice to an external regulatory body. I know the possibility of such an external body was an important aspect of the GMC's thinking when discussing revalidation processes with Colleges.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Since one of the aims of recertification is to provide assurance of a doctor's continued fitness to practice, any process that leads to such a summative judgement should be mandatory. For instance, asking patients and colleagues in their questionnaires whether they have confidence in their doctor (from the patient's perspective) or whether the doctor is fit to practice (from the colleague's perspective) should be mandatory. Another possibility is the forming of a judgement by a panel of reviewers of a doctor's continued fitness to practice taking into account all the evidence it has, including patient and colleague questionnaire responses, and an audit of the doctor's records over the previous 36 or 60 months. International research shows that, if patients are confident in their doctor, they are more likely to stick to and complete their treatment regimes, leading to better outcomes. My own statistical research and publications show that colleagues use questionnaire items subtly to raise concerns, leading to some doctors becoming statistical outliers who can then be supported with further mentoring and retraining programmes.

Q6 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?

I cannot answer this because I don't work for a practice or hospital.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Thank you for giving me the opportunity to comment on your proposal. My comments above are meant to be constructuve and I hope they are helpful.

Page 2: Submission information

Q8 Your information:

Name	**Ajit Narayanan**
Company	**Auckland University of Technology**
Email Address	[redacted]

Q9 Your position/title:

Professor in the School of Engineering, Computer and Mathematical Sciences

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 9:30:35 AM
Last Modified:	Friday, September 07, 2018 9:36:10 AM
Time Spent:	00:05:34

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Way too complex and still no evidence basis.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Have two groups 1/2 the GPs under regular system as stands and 1/2 the GPs under the new complex and survey laden system, then devise a way to measure and judge outcomes and use that evidence.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes - less and less GPs per capita of old complex patients to provide care so that all the time out to fulfill multiple criteria for recert means even less availability to care for pts and more stress and thus circle of more burn out etc.

Q4 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?

Yes - cost increases to college thus cost passed on to doctors.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes - CME hours

Q6 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?

No issues, most people can create a colleagial relationship and find an hour a month to get together.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Get rid of all the surveys, except maybe the 360 degree.

Page 2: Submission information

Q8 Your information:

Name	**Norma Nehren**
Company	**Te Hiku Hauora**
Email Address	[redacted]

Q9 Your position/title:

MD, GP, Medical Director, FRNZCGP, board certified ABFM

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:16:00 PM
Last Modified: Thursday, September 06, 2018 6:30:17 PM
Time Spent: 00:14:16

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It sounds reasonable.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

More funding in primary care so that we have enough paid time to learn and to review.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Not enough paid time to improve learning and ti improve a quality of care due to lack of funding.

Q4 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?

Doctors end up spending more time and money to meet whatever goal medical council puts. More funding and more GPs will partly solve the problem.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Not more that what we have now.

Q6 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?

A peer review that I can participate from home will be great. Igf government funds a structured peer review group on top of the one in my own clinic, that will be great.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

More funding in primary care.

Page 2: Submission information

Q8 Your information:

Name	**Noriko Noda**
Company	**Bushroad medical centre**
Email Address	[redacted]

Q9 Your position/title:

General practitioner (fellow)

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 8:39:28 PM
Last Modified:	Thursday, September 06, 2018 8:41:49 PM
Time Spent:	00:02:20

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't increase the workload or time it takes

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, September 09, 2018 1:56:07 PM
Last Modified:	Sunday, September 09, 2018 2:03:09 PM
Time Spent:	00:07:01

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I think that a move towards the inpractice recertification requirement for generally registered doctors is a huge mistake. While your reports may say this is working well, on the ground it is a waste of time. The process is adhered to out of compulsion, with no meaningful benefit - often patient surveys are filled out by colleagues, goals are made up and completed on the spot, etc. It is widely seen as a bureaucratic tick boxing exercise.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, September 12, 2018 8:32:28 PM
Last Modified:	Wednesday, September 12, 2018 8:40:42 PM
Time Spent:	00:08:13

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They are appropriate

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

RPR useful. Could be compulsory on an annual basis. Expensive loss of work time for assessor

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Gradual change best to take everyone along. Too rapid: too many non compilers.

Q4 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?

What about part time practitioners eg parents of young children, semi retired and locum? Some sort of pro rata. Maybe 50% of points if 5/10 or less.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

RPR

Q6 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?

Docs in solo practice in rural locations/smaller centres

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Avoid going to revalidation. Learn from mistakes in U.K. Medical workforce

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, September 24, 2018 10:29:13 AM
Last Modified:	Monday, September 24, 2018 10:38:59 AM
Time Spent:	00:09:46

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Multisource feedback is useful, but it tests interpersonal relations more than the knowledge base. And it is the knowledge base that fades with time unless refreshed rather than the relationships.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

More directed towards getting updated with latest EBM

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

___

Q4 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?

—-

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

ACLS, and CME for general practice updates.

Q6 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?

—-

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Not yet

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 5:34:34 AM
Last Modified: Monday, September 10, 2018 5:52:39 AM
Time Spent: 00:18:04

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Generally positive, but my concern is to not make the reflection on learning needs more time-consuming than actually addressing one's learning needs. So much of what a doctor does when upskilling is nearly automatic: I find that I don't know enough about something, or I reflect that I didn't handle something as well as I would have like to, so I then take action. Slowing this process down to make each reflective step explicit & documented could be counterproductive, & lead to a cynical tickbox approach rather than true change in practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Need streamlined processes: the reason why approved CPD appears to be such a high proportion of my overall MOPS is that it is far easier to implement. In fact, it is only a small proportion of what I do in order to maintain and improve competence but the process of documenting the self-directed activities is more onerous.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

More administrative time means less time actually improving practice.

Q4 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?

No, but in all cases recertification processes need to be streamlined and in the main be set up by practising doctors, who also have to go through the process themselves and hence can see any pitfalls.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer discussions.

Q6 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?

Ones based within the workplace rather than external providers. Doing this with familiar, trusted colleagues allows one to be genuine about one's abilities & uncertainties, and open to suggestions for improvement, rather than feeling that one is in a pass/fail examination by an external provider. Trust is essential: without having an ongoing relationship with the peer reviewer, the gains will be more limited.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Thank you for the opportunity to give feedback: this is an essential ongoing key to 'buy-in'.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 4:30:42 PM
Last Modified: Monday, September 10, 2018 4:39:38 PM
Time Spent: 00:08:55

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am in support of this strengthened approach. We need educational activities to be directed towards clinician and peer identified areas of need. They need to be evidence based. Need to move away from an hours based approach where compliance is measured by sitting in conferences etc. A strengthened practice and peer review framework would be very useful.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Strenthen use of professional development plans.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Regular practice review is a great idea, but enormously time consuming. As clinical director for a service with over 30 doctors, it's hard to see how this could be practically achieved. Similarly in a hospital setting a lot of outcomes and pathways for inpatient care reflect the care of the team as a whole. The individual doctor is only one part of the system that creates the outcome. It is great to use evidence of direct individual practice to identify learning needs, but in a large service this can be easier said than done. Multisource feedback is good at identifying interpersonal skills, professionalism etc.

Q4 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?

Same concern regarding workload to achieve practice review. The medical work of the college is very much on a voluntary basis, with relief from the DHB employers. This is a relatively small group of individuals. Careful thought as to how to implement any individual practice review will be necessary. There will be a considerable expense for this, which will not be able to be met under current college funding, and the employer will likely need to meet the cost.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Multisource feedback including patient feedback. A self-directed structured learning process. Peer review (which should definately include service review such as m and m etc)

Q6 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?

MSF, incident review

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Chris Peterson**
Company	**Waitemata DHB**
Email Address	[redacted]

Q9 Your position/title:

Clinical Director Child Health

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 15, 2018 8:37:24 AM
Last Modified: Saturday, September 15, 2018 8:49:37 AM
Time Spent: 00:12:13

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree with the goal of a programme aimed at the individual learning needs and goal/intended scope of practice of the clinician as at the moment I think inpractice does not meet this need

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Individualised. Not everything in inpractice applies, particularly for those intending to apply for surgical training programmes. I think there should be alternative programme available for those with surgical interest eg jdocs which is associated with RACS. I don't think patient feedback questionnaires are worth the significant effort and time required to collect them, particularly as it's the same individual's responsibility to ask the patient to do the feedback and are also part of the team responsible for their care. Colleague feedback and multisource feedback is good. Compulsory audit each year is okay but a research project should also be acceptable.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Is this referring to your boac supervisor? Main issue is getting a time to meet.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME hours. Multisource feedback (except patient feedback). Supervisor/mentor.

Q6 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?

Should be someone who works directly with you.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 12:20:56 AM
Last Modified: Friday, September 07, 2018 12:31:37 AM
Time Spent: 00:10:40

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Nebulous and imprecise

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Unclear why recertification needs amending at all

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The nebulous nature prevents the formulation of concrete plans

Q4 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?

The potential for more time-consuming and resource-consuming recertification with no obvious tangible benefit

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Regular conference attendance, regular journal reading

Q6 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?

Audits

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

This seems like a costly way of appearing to innovate when there is little innovation and change

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, September 11, 2018 12:24:25 PM
Last Modified:	Tuesday, September 11, 2018 12:39:35 PM
Time Spent:	00:15:10

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Good to see a comprehensive review of recertification and some aspects will be realistic on an annula basis. However the practice review component would be very onerous at anything less than 3 yearly - perhaps it should be only every 6 years. If the PDP is done well then the need for RPR is likely to be less.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Colleges will need to consider how to implement the key components

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Cost of undertaking the RPR could be considerable along with having sufficient people trained to do the work. It would be helpful to have consistent templates for PDPs, 360 reviews that have been validated;

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

The activities are all focused on individual practice. There also needs to be a focus on improvements of the health care system and on the leadership requirements for that. I think leadership training nad development should form a part of everyone's recertification programme

Q6 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?

see above

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Need to be proactive about getting doctors to engage on this. The recent approach the MAS took on engagement with members via on line discussion was effective and should be considered

Page 2: Submission information

Q8 Your information:

Name	**Marion Poore**
Company	**Southern DHB**
Email Address	[redacted]

Q9 Your position/title:

Public Health Physician / Medical Officer of Health

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 7:01:15 PM
Last Modified: Thursday, September 06, 2018 7:19:57 PM
Time Spent: 00:18:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I have previously been involved in the UK revalidation process. The was a hugely expensive and time consuming exercise. In my last revalidation I submitted 242 electronic documents, NOT including CME documents. This process took hours to prepare for and took considerable FTE from the clinical time of peer assessors. Even failing doctors can pass these assessments: They make the medical councils feel that they are adding to patient safety by enforcing a barrage of paperwork with little evidence to prove any value in the expensive and time-consuming process.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Minimise the administrative burden above what is already required by the medical colleges.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Cost and time. FTE is already stretched. The UK system required multiple SMOs giving up 10-25% of FTE to process the revalidation system. Please avoid this.

Q4 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?

Make sure there is clear evidence base that any recertification process actually is of value.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes: CME, Peer review, Appraisal, PDP, QI.

Q6 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?

M&M, SMO to SMO case discussion sessions.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Do not copy the UK system. Burdensome: ticking boxes and collecting inconsequential evidence.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, November 01, 2018 9:46:10 AM
Last Modified:	Thursday, November 01, 2018 9:49:49 AM
Time Spent:	00:03:39

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

seem ok

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

make it simple

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes the cost of it- partically in general practice now with fixed fees with a lot of the patient base

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

cost and funding of it in general practice

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

suggest funding increase for NZ government to compensate for cost of it in general practice

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:10:06 PM
Last Modified: Thursday, September 06, 2018 6:16:16 PM
Time Spent: 00:06:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Any proposed change probably lacks any evidence of benefit

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I wouldn't implement them.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Turning doctors off wanting to come to NZ.

Q4 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?

Making it like the UK which has made doctors retire and emigrate. My suggestion would be to save money and stress and not do anything

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

Yes, I think they will likely be out of touch, and tick box based, which is not useful.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't do it for the sake of it. It seems like an idea which will make MCNZ unpopular. If your aim is to undermine the workforce, go ahead.

Page 2: Submission information

Q8 Your information:

Name	**Paul Riley**
Company	**individual response**
Email Address	[redacted]

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 10:19:19 AM
Last Modified:	Wednesday, October 31, 2018 11:03:08 AM
Time Spent:	00:43:49

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They seem sensible

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The feedback from Colleagues in the surgery can be via Questionnaire like the feedback from patients seen at the surgery

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Not really

Q4 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?

Recertification providers would have to be Vocationally Registered in the realm of Practice they are Recertifying. They would probably only be able to cope with a small number of doctors requiring Recertification as they would be required to be practicing themselves in that Vicational realm. This would require a large number of Recertifying Doctors. They would need appropriate remuneration for this service to make it worth their time

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes, Specified CME, ☺Feedback from colleagues and patients, Peer Review

Q6 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?

I fibd a good Peer Review group very helpful and informative. I work as a locum in different practices all over NZ. Some Peer Reviews are a waste of time

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**W Steven Ringer**
Company	**W.Steven Ringer**
Email Address	[redacted]

Q9 Your position/title:

Peripatetic GP Locum

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 8:47:27 AM
Last Modified: Friday, September 07, 2018 8:55:09 AM
Time Spent: 00:07:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

not required and make an already onerous process more difficult

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

as far as I see it they are already present

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

i do not see a need to make and already robust and time consuming process more so

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

leave it up to the individual branch of practice to decide

Q6 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?

no , as an OPTION

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

this may be the final straw to cause some older doctors to retire earlier than planned

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 9:59:06 AM
Last Modified: Wednesday, October 31, 2018 10:04:50 AM
Time Spent: 00:05:43

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think that this is a solution looking for a problem.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't implement them

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes - they look like just a more complicated tick box

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

What is RPR? Not defined (that I could see) in the document you sent out

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

If this is evidence based then publishing your literature review would be a good start. Most doctors are used to using evidence to guide practice and good evidence speaks for itself.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Saturday, September 08, 2018 1:54:16 PM
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Time Spent:	00:03:20

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

reasonable supportive systems would help achieve this

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

RNZCGP porcess is adequate

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

no

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

we do in practice peer reivew and a larger GP grouping it woeks well

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**Helen Rodenburg**
Company	**ibmc**
Email Address	[redacted]

Q9 Your position/title:

gp

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 11, 2018 10:05:17 AM
Last Modified: Tuesday, September 11, 2018 10:19:21 AM
Time Spent: 00:14:03

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am currently revalidating in the UK. I think patient feedback surveys need very carefully making. In the UK 30 feedback questionnaires are required and so far zero of mine have any tips for improvement or comments that can lead to useful development. They are also collated by the doctor so negative ones could remain unseen/ unsubmitted. I don't think this is useful in the format used by the UK.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think recording audit/ mortality meetings is a good component, but how should this be evidenced. Usually the minutes of such meetings/ power point slides used are confidential and include images, so in terms of evidence I am unclear on what can be used.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Gathering useful patient feedback as many patients are reluctant to give doctors any tips for improvement, unless confidentiality is guaranteed (and even then I believe many with ongoing care needs may hesitate)

Q4 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?

Confidentiality with regards to evidence submitted to support audit/ quality improvement activities

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

A face-to-face meeting with a peer which includes review of 360 degree feedback from staff members and review of complaints and compliments and CPD activities

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 3:37:08 PM
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[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The basis seems pragmatic and a positive step forward. My only concern is the time factor in an increasingly time-pressured system (especially in rural areas, and in the aftermath of the RDA agreement) and resource available to undertake certain portions of this, particularly good audit and outcome-based CPD

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Audit could potentially be in association with registry-based data (potentially easier in nephrology) - there needs to be a clear mandate to require DHBs to provide the relevant time and resource with which to undertake good audit as part of improving patient care

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time and resource with which to undertake this as part of a meaningful exercise to improve patient outcomes

Q4 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?

Vital to involve NOT just tertiary clinicians, but also regional perspectives

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

MSF every 3yrs; reflecting clinical and non-clinical concerns about the organisation within which they work - not only highlights concerns about the individual but also the wider establishment

Q6 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?

MDT handover discussions work well within our team as part of peer review as do journal club discussions

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Seek active participation of regional clinicians along the way to enable buy-in and smooth implementation

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 11, 2018 4:07:36 PM
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Time Spent: 00:03:05

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The Collge of GPs does a good job > increase its process

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Disagree

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Endless

Q4 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?

More funding and support and dialogue with MCNZ dont duplicatre the woek

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

there is a process at the moment NO

Q6 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?

Collegial meetings

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Disagree with your suggestions

Page 2: Submission information

Q8 Your information:

Name	**Nina Sawicki**
Company	**QFHCL**
Email Address	[redacted]

Q9 Your position/title:

Director

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 25, 2018 4:39:45 PM
Last Modified: Tuesday, September 25, 2018 4:55:01 PM
Time Spent: 00:15:15

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

overall i think they are good and the RNZCGP of which I'm a fellow follows a very similar approach already

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Review the RNZCGP triennium requirements. We already have regualr practice review assessment available but they are expensive at present and for memory around $2500. Another issue is lack of support from GP businesses to support their GP's meeting CPD expenses. My last job offered $1000 per annum. Hospital coleeagues ahve much more access to funding. I think GP business would not endorse extra expense in an already tight market place. I already do my own self directed PDP that suits my style of learning and I think there should be some allowance for individualised programmes. I also feel there should be CPD variations due to large scope of GP. we now have GPSI and have military medicine GP's and there should be some flexibility to enable CPD in these areas and areas of need for particualr jobs. Maybe a basic set of CPD requirements with another set of hours dedicated to your area of specialisation

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

as above

Q4 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?

Think the GP college will cater to the majority but I think special areas needs some alternate option. I work in [redacted] and my learning needs and CPD needs are different to regualr suburban GP work. This would also apply for example to skin GPSI or musculoskeltal GPSI and even say doctors in research or high admin roles with small clinical role

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Resus should stay mandatory, a think PDP with peer review of plan should stay, Audit should stay. More flexibility around peer review and CPD activities- some docs work in isolated areas and sometimes maintaining the peer review requirements can be challenging

Q6 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?

I have already had a new peer review group endorsed by the GP college. It consists of GP's, nurses, and medics. I think it should not just have to be the traditional must be MO or GP to attend. RPR- I can't see most business absorbing expense of a RPR at present in civilian practices. So cost is an issue I can forsee

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Flexibility amongst specialiaties. I'd expect my recertification requirements should be vastly different from a hospital specialist requirement. I think teaching should also be more recognised as a very valuable professional development tool in the recertification process.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 5:05:08 PM
Last Modified:	Friday, September 07, 2018 5:06:23 PM
Time Spent:	00:01:15

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Mostly theoretically good, practicalities need work, need to be incorporated into exiting College CPD programmes rather than separate and additional

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Need to be recorded through existing College programmes. There would be significant increased workload to vocationally trained specialists to complete a MCNZ recertification online programme in addition to the College programme.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Annual professional development reviews should be occurring anyway, but they often don't. This is not due to the reticence of SMOs but time and production pressures and availability of SMOs and Clinical Directors / Managers to perform these. There risks the SMOs getting caught in the middle of under-resourced departments / DHBs and MCNZ requirements.

Q4 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?

Keep it simple. Colleges add on the specific requirements for MCNZ to their own CPD programmes - as is currently with the MCNZ audit. Trying to create a duplicate system will not achieve the goals of increased reflection. Instead it will increase frustration and become a tick box exercise

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

To be honest, college (ACEM in my case) CPD requirements are already robust enough. I'm not sure that the audit requirement has fulfilled the educational and practice-improvement goals that were anticipated. Anecdotally, some years the audits are robust and achieve aims, others they becomes a tick box exercise of low quality. A fundamental issue is that educationally, most practitioners reflect on their practice through their CPD. Those that don't are suddenly going to because MCNZ mandates it. The group that need targetting will not be picked up by self-reflection activities; self-reporting and even MSF has a high risk of skewed feedback (not going to ask someone you know will be highly critical). Professional Development reviews are good, but are an employment contractual issue rather than within the remit of MCNZ unless there are practice issues. Stick to individual College CPD requirements. All the things suggested are already possible within them. Nothing else should be mandatory on top of them.

Q6 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?

Fine as an option; not mandatory. Has implications with DHB funding for resourcing

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Integrate into College CPD programmes. Need to minimise extra work for an already overloaded SMO workforce

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Wednesday, November 14, 2018 9:41:52 AM
Last Modified: Wednesday, November 14, 2018 10:04:59 AM
Time Spent: 00:23:07

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree that recertification should be relevant to the individual practice role and workplace. Given the change in roles over time and the requirement to maintain registration for activities which require specialist knowledge but do not involve clinical practice, the requirements should be flexible to the individual's changed roles.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The Medical Colleges are the key component as now but may need to change some of their requirements to be relevant to NZ especially the bi-national colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Reamining relevant to individual roles rather than one size fits all will require comprehensive consultation with Colleges, Specialties, Employers and individuals

Q4 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?

See above. The bi-national Colleges will need to look at how their recertification matches the NZ jurisdiction. For example the Royal Austalasian College of Surgeons has medicolegal roles which are more aligned with Australian conditions than NZ. This would need to change to be relevant.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Scientific meeting participation, medical evidence currency, educational peer activities

Q6 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?

I work [redacted] as part of a panel of advisors. The Panel meets weekly to discuss files and relevant evidence to support our advice. Given that there is no clinical practice involved the use of proposed RPR as outlined may not add any value.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Wide participation of the relevant organisations, specialties and individuals will be requires to keep the process on track and relevant to practicing doctors whatever their role

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:46:17 PM
Last Modified: Thursday, September 06, 2018 6:03:05 PM
Time Spent: 00:16:47

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Looks very similar to current CPD for anaesthesia which are not just time based but quality based, ie emergency response activities, audits, peer review etc. SO for anaesthesia I am not sure how much would change?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I imagine implementing this would be an extension of what already exists. Not sure about other specialities but the anaesthesia college has put masses of effort to continually review and improve CPD program to make it relevent to our practise and competence. Very happy to be part of audits bit I do wonder about the value of individual audits which are not referenced to any particular expected standards

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No. I expect what we do currently is quite similar

Q4 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?

Communication is paramount

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

EMERGENCY RESPONSE ACTIVITIES, PATIENT FEEDBACK surveys, evidence based audit

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, September 12, 2018 11:04:38 PM
Last Modified:	Wednesday, September 12, 2018 11:11:37 PM
Time Spent:	00:06:58

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

very good

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

In a timely manner

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

no

Q4 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?

Make it more simplified

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

sure

Q6 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?

no

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Please don't make it too tough

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, November 04, 2018 2:39:57 PM
Last Modified:	Sunday, November 04, 2018 2:50:42 PM
Time Spent:	00:10:45

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It looks good on paper, practical cost effective application may be difficult

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Cost. Especially of any practice review activity.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Balint group or other supervision by qualified persons at least 1 hour monthly

Q6 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?

Training of reviewers. Cost and who pays?

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, September 16, 2018 4:08:38 PM
Last Modified: Wednesday, October 31, 2018 3:02:55 PM
Time Spent: Over a month

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

If we're talking with patients about a complex medical issue the aim is to use language which is straightforward and without jargon. The Medical Council should try and explain it's aims and intentions similarly without hiding behind educational jargon.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

no

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

time availability and expertise of those involved

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

in subspecialty medicine there may be very few peers so it is hard to relate to this aspect

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

ensuring there is adequate resource and readily available expertise to assist

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, November 01, 2018 2:15:31 PM
Last Modified: Thursday, November 01, 2018 2:46:04 PM
Time Spent: 00:30:33

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Generally agree.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Promoting attedance and presentations at international conferences.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Weak or virtually non-existent monitoring, oversight and audit mechanisms within organisatios.

Q4 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?

They need to be more proactive in providing practice updates and lessons learnt from post-hoc analysis of adverse events.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Attending at least one national and one international conference each year to gain peer exposure and first hand knowledge of latest advances..

Q6 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?

Peer review, in my view, does not mean 'you scratch my back, I scratch yours'. Their should be an evidence-based and critical evaluation of practices.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Renewed emphasis on an evidence-based approach, combined with robust efforts aimed at translating evidence into practice.

Page 2: Submission information

Q8 Your information:

Name	**Digvijay Singh Goel**
Company	**Southland Hospital, Southern DHB, PO Box 828, Invercargill 9840.**
Email Address	[redacted]

Q9 Your position/title:

Consultant Psychatrist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 11:31:44 AM
Last Modified:	Wednesday, October 31, 2018 11:37:12 AM
Time Spent:	00:05:27

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Too much time and effort required for little gain.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Doctors are busy, reimbursement should be made if people are expected to take part in these activites.

Q4 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?

Requirements to keep up with certain topics in CME.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Yes

Q6 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?

Will people be reimbursed for their time?

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 4:25:27 PM
Last Modified: Wednesday, October 31, 2018 4:42:37 PM
Time Spent: 00:17:09

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They sound "nice" but I don't understand what they mean and therefore how they will transfer to my practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I am very concerned that there will be multiple programmes that I will be expected to complete. I already have CPD for my college, who also expect me to collect data for colposcopy certification which is different from the data the NZ MOH collects by default. My college has advised me I will have to conform to the AMA recertification guidelines and now there are a proposed set of NZMC guidelines. It will get to hard for someone like me who is towards the end of my career and is working providing relief cover to my colleagues working in small understaffed DHBs. I am particularly uncertain about how I can audit my locum practice

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

audit when I only do locums

Q4 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?

Talk to Australai and have only one set of programmes for both countries and all states

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No.

Q6 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?

What is RPR. Medicine is now full of abbreviations and uncomprehensible jargon

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Please use language that is understandable. I currently do PAR and PD and do not understand what activities each of these are. The college people collecting this could not explain it to me either. Just told me to put activities into either section

Page 2: Submission information

Q8 Your information:

Name	**Anne Sissons**
[redacted]	

Q9 Your position/title:

Doctor

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Wednesday, 31 October 2018 7:12 p.m.
To: Strategic Consultation; [redacted]
Subject: Re: MCNZ - Strengthening recertification for vocationally-registered doctors

Dear Andrew

Is the MCNZ not reinventing the wheel?

The NZOA run a very comprehensive recertification programme - are orthopaedic surgeons to be recertified twice

Perhaps the president elect of the NZOA could comment but I dont see the need for this in the case of my speciality

[redacted]

On 31/10/18 9:00 AM, Medical Council of New Zealand wrote:

> Dear Colleague,
>
> For a number of years now, the Medical Council of New Zealand (Council) has been working towards strengthening how we ensure doctors practising in this country are up to date and continue on the path of lifelong learning.
>
> Recertification is a process that gives assurance to Council, medical colleges, and most of all to members of the public, that doctors are undertaking activities to ensure they remain up to date and provide opportunities for continued professional development.
>
> You may be aware that Council has been consulting on recertification. The current discussion document, which is out now for feedback, is the culmination of extensive consideration, discussion and research. It provides context of where we have come from, what the evidence tells us about what works (including a literature review undertaken to consider this), and proposals for where we could go next.
>
> I would encourage you to read the newsletter which contains further information around recertification at the link below. You can also find further information about the consultation on Council's website.

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 08, 2018 11:52:39 AM
Last Modified: Saturday, September 08, 2018 11:58:53 AM
Time Spent: 00:06:13

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Complete waste of time - pointless , will prove nothing, will just make busy doctors' lives harder with no benefits; will fail to weed out defective individuals, and simply cause stress to good doctors. Honestto God, does the medical council have nothing better to do with its time?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't implement them at all - utterly pointless

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Just more crap for good doctors to deal with. Why are you trying to fix a prpblem which isn't there?

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CPD - that's all that counts

Q6 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?

Totally unnecessary

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't implement them at all

Page 2: Submission information

Q8 Your information:

Name	**David K Smylie**
Company	**Cambridge Medical Centre**
Email Address	[redacted]

Q9 Your position/title:

GP partner/director

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Thursday, 6 September 2018 6:01 p.m.
To: Strategic Consultation
Subject: Feedback on MCNZ revalidation

Categories: Blue Category

Dear Carol Parreno

I am feeding back as we have been requested, regarding the proposed changes to revalidation. At present I think revalidation is structures to identify the poorly performing doctor or the isolated practitioner, nor does it assess the best way to keep up to date. I am concerned that it is a 'closed shop'- ie the only way at present in internal medicine to achieve revalidation is through the RACP scheme.
The RACP have not put any resources into helping their members achieve some of the MCNZ review of practice or professional development programmes.
I suggest that robust resources are provided for 360 degree feedback, patient feedback (via questionnaires), peer review etc. These would need to be face to face and on the ground activities. This makes them time consuming and expensive.
As an academic we have these processes in the University for teaching- IO think a robust supported rolling roster fo activities should be planned – over say 3 years, with workshops bookable for these activities through the employer or regionally for those practicing outside the DHB or in isolated settings

Yours sincerely

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, November 01, 2018 4:02:59 PM
Last Modified: Thursday, November 01, 2018 4:07:29 PM
Time Spent: 00:04:29

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Great idea but more focus needs to be on those not doing vocational training

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Run by individual colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Great idea but more focus needs to be on those not doing vocational training

Q4 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?

Use a dr from a different region

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME

Q6 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?

Hard to organize - current peer review meetings work well

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Great idea but more focus needs to be on those not doing vocational training

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Wednesday, 31 October 2018 9:40 a.m.
To: Strategic Consultation
Subject: feedback on consultation

Categories: Blue Category

Dear Carol
Thank you for the opportunity to feedback on the "Recertification" document
I understand that the primary focus –or aim of this is ultimately to protect the public and provide high quality health care.

As a person who provides collegial support to non vocationally registered doctors and having a partner who is in the MCNZ process for non vocationally registered doctors I think I can make some pertinent comments.
I observe that in fact the MCNZ process for non vocationally registered doctors is in many ways more rigorous than for the vocationally trained group-.
Part of this is the face to face meetings and incisive practice review where the practitioner is actually seen at work.

Whilst I agree with most of what is in the discussion document, the success or otherwise will fall to the professional groups – generally the Colleges.
The problem with this is that it depends hugely on the College in question and their ability to mount a process which is in line with the MCNZ discussion. document. Colleges tend to assume knowledge and skills because they are a "guild" and wish to provide outcomes in CPD-CME with least hassle to their members. Colleges do believe in CME but tend to work on the premise that because the Fellowship is working in the discipline, to a greater or lesser extent, hours does equate with work place activities. As MCNZ is well aware, this will generally work in major institutions, but in small units and /or private practice there is a real risk of professional isolation.

I am aware of practices occurring in New Zealand which are not supported by Colleges or the MCNZ but slip under the radar in the current system because the doctor is vocationally registered. I am thinking of ozone therapy as but one of a number examples I can give which are occurring in General Practice and the current system will not detect this. Only by actually doing detailed practice visits and looking at patient appointment lists will this be detected and stopped.
In my speciality, I can also give examples eg in endometriosis surgery and of course in the use of surgical mesh where suboptimal practices have and do occur.
I am also concerned about the lack of knowledge about Women's Health that is now apparent in general practice. (The reasons for this are complex but the issue is poorer care for women).

So my concern in all this , is that the proposed process will really provide both an educational but also a regulatory process that meets the MCNZ and the public's needs.
Thank you
Yours sincerely

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 08, 2018 4:37:40 PM
Last Modified: Saturday, September 08, 2018 4:48:38 PM
Time Spent: 00:10:58

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Perhaps ensuring that registrars of particular specialities and other junior doctors fill a certain quota of required procedures and/or basic surgeries.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Increase the capacity for pastoral care between consultants and/or senior registrars with their juniors/house officers. Avoid the implementation of the Schedule 10 rostering system, which will take registrars away from their teams for longer.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Discussions between the RDA and Hospitals regarding misappropriation of the concept of 'safe working hours' Finding time to pin consultants down as they are quite busy. Making them understand how keen you are to progress.

Q4 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?

Consultants should monitor consultants, I suppose. One could consider 'check' consultants much like they have in the aviation industry - I mean this is not a new concept...

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No, because once you start introducing mandatory regulations, it stunts career growth through requirement to progress out of necessity rather than desire and dedication - much like is the case with current research requirements for many training programs - More research of lesser quality is produced; blocking research attempts by those that have a legitimate interest in the field.

Q6 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?

Yes, see above comment. In addition, a one size fits all model cannot be applied as many specialties are different doctors within their respective areas of expertise must be left alone to govern themselves through leadership.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Happy to be part of further discussion as I've been quite taken by the terrific system here and becoming a part of it as a New New Zealander.

Page 2: Submission information

Q8 Your information:

Name	**Andrew Suchowersky**
Company	**Auckland City Hospital**
Email Address	[redacted]

Q9 Your position/title:

Orthopaedic Registrar

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 10:06:27 PM
Last Modified:	Thursday, September 06, 2018 10:58:09 PM
Time Spent:	00:51:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I feel apprehensive at the thought of requirements being percentage based. Given that I am an avid consumer of conferences, seminars, workshops etc, does that mean I would have to increase the amount of time I spend on audit activites (for example) in order to meet certain percentage requirements? That seems unfair.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think flexibility is important. I happen to have a great peer review group, but I know not everyone is so lucky. Giving people different ways to achieve the same goals would be helpful.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Because I am a sole GP I always find the Professional Development Plan the most onerous aspect of my MOPS. I would love it if this activity was offered as a workshop at the annual conference so I would be able to feel that I wasn't taking up another busy doctor's time to sign off my PDP.

Q4 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?

I know it costs money, but it's money that I would be happy to pay to have a coordinator from the college send me reminders/work with me etc to ensure I have all my requirements up to date at the right time. I'm too busy working (and attending seminars, doing my own research relevant to my patients problems etc) to enjoy devoting time to this sort of admin.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Resus, supervision

Q6 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?

Our peer review group is lovely. Members are invited to join and they attend to check that they fit the group before they become full members. We have supportive time of sharing stuff that is going on in our lives and in our work. Some occasions we invite a speaker on a topic of relevance to us and other occasions we discuss cases, sometimes on a theme, sometimes one doctor brings their cases from that day and we randomly choses ones to discuss. It's great learning and support for us all.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I expect that just about every doctor that is well and is coping with life will naturally be doing well in continuing to improve their practice throughout their career. People don't normally get to be doctors unless they are keen on learning and care about people. I think the doctors that need extra attention to meet your goals are the ones that are having difficulties in their lives. I think that is the most important area to address.

Page 2: Submission information

Q8 Your information:

Name	**Tralee Sugrue**
Company	**Dr Tralee Sugrue Ltd**
Email Address	[redacted]

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 9:07:37 AM
Last Modified: Wednesday, October 31, 2018 9:21:24 AM
Time Spent: 00:13:46

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Good

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

These are already extensively documented in my own colleges CPDP (Pathology), therefore further duplication of such documentation would be unnecessary and time inefficient.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Our college has a well researched programme which has been in operation for at least 10years.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

These are already extensively documented in my own colleges CPDP (Pathology), therefore further duplication of such documentation would be unnecessary and time inefficient.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, November 08, 2018 10:18:48 AM
Last Modified: Thursday, November 08, 2018 10:23:34 AM
Time Spent: 00:04:46

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Looks fine

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think my college could further develop practice review procedures

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Usual service demands on time with DHB employers

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CPR periodically to an appropriate level

Q6 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?

I think collegial visits annually for a day including surgery. Commercial considerations might make a colleague from a distance more appropriate

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:

Name	**Antony Suter**
Company	**Nelson Hospital**
Email Address	[redacted]

Q9 Your position/title:

Ophthalmologist

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Monday, 10 September 2018 9:36 p.m.
To: Strategic Consultation
Subject: Attn:- Carol Perreno

Categories: Blue Category

Feedback regarding Recertification.
The vision as stated is quality education. I am happy about that.
I have for many years been involved in recertification. I have had many discussions about the process with colleagues at the conferences and workmates.
Apart from quality of the education please consider this:- KEEP IT SIMPLE. The present process is clunky, clumsy complex. Everybody I speak to complains about it. They become disengaged with the process. CME and Peer review are great.
Forget about cultural competence. Cultural competence is meaningless in most areas. I have more asian patients than maori patients. I understand that is not everywhere. Doctors that work in areas with a large maori population by necessity become culturally aware. I pity the young GP starting off now and having to do cultural competence for the next 30 - 40 years. No wonder everybody roll their eyes at its mention. Disengaging.
Another problematic area is Audits. Totally meaningless for everybody. It could become meaningful if we had the time to do a proper audit it but we became GPs to treat patients not do Audits. We don't have the time to do them. Education value nil. I asked some specialists if they also need to do audits for recertification. Apparently they do but all of them said they get their hospital registrars to do them. It is has no value. I can imagine people in the ivory tower thinking what a great idea it is but I believe that would change if they came down to the coalface. I am not alone thinking that audits are a complete waste of valuable time and have no educational value.
It all goes back to keeping the recertification process simple. CME and Peer review = 50 hours per year.
Kind regards,
[redacted]

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, September 24, 2018 11:52:59 AM
Last Modified:	Monday, September 24, 2018 12:00:28 PM
Time Spent:	00:07:28

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It is good having RPR and using a combination of evidence-based measures and innovative models that have a clear goal and intended outcome, as long as they're clearly demonstrable to be relevant to the doctor's practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

There needs to be distinction between clinical and non-clinical recertification eg. if a public health or health policy doctor was being recertified, their requirements would differ from that of a doctor practicing clinical medicine in a hospital. The same goes for locum and part-time doctors, and doctors on gap year/stress/personal leave etc.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The flexibility needs to meet the needs of both the doctors who are on gap year/stress leave/etc, and that of fulltime doctors. The medical colleges need to understand this.

Q4 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?

Too rigid in recertification processes. Flexibility and openness to other areas of interest eg. HiNZ activities, need to be discussed and understood by the colleges.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

[redacted]

Sent: Tuesday, 6 November 2018 2:16 p.m.
[redacted]

Late feedback!

I focus my comments on the proposed approach

1) Profession led – yes agree and this should be the colleges. In turn the process should link with employer professional development programmes
2) Evidence – I am really not sure what is meant by that – evidence of audit? Audit is easier for some specialities than others, and variably supported by employer systems notably IT systems. For example, there is a national cardiac surgery data base – all funded by MOH but no such luxury for most other non interventional services. DHBs lack the infrastructure to support this and I suspect many private providers do as well.
3) Education and development relevant to workplace – totally agree. That requires employers to have in place good processes for supporting doctors be they in primary or specialist care. Not sure how this works in private practice where the practitioner is sole. Colleges clearly have a large role but have not been active in career planning.
4) Use of a PDP - Frankly I do not find these that helpful as things often change. I think something that is goal orientated e.g. my next job is …., or my next skill acquisition is XXXX is fine but some colleges demand and annual PDP and I find that overly bureaucratic
5) RPR. Fine to have the colleges offer it but it is impossible to provide to everyone – expensive and time consuming.
6) Specified CPD hours: important that we are not too prescriptive. Already it is a time consuming process logging all the points under the various categories……
7) Flexible approach – yes agree. And audit might be replaced by participation on hospital adverse event review committees or other such opportunities to review practice and patient safety.

At the end of the day this approach is always going to be limited because the things that are hard to measure are quite possibly the most valuable e.g. reflective practice, and the things that are easy to measure (number of publications) might merely indicate serious research intent, not necessarily clinical competence……
And those in the procedural specialities can have their PA press a button and all the data downloads from the software designed for and paid for them by the DHB…

[redacted]

[redacted]

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 10:59:25 AM
Last Modified:	Wednesday, October 31, 2018 11:10:40 AM
Time Spent:	00:11:15

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree with current principles as set out in the vision statement. Dont make it onerous on the GP's to fullfil, but should set the minimum standard, rather than the maximum standard/Excellence.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

PDP could be sorted within GP setting , with Outside Review once every 5 yrs.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Increased work load and cost, this will in turn result in increased fees to the consumer , The patient. Keep the process simple and as cost effective as possible.

Q4 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?

As in Qu.2

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Thought could be given to the "Minimum Standard" . Cornerstone is an example of "Excellence ion GP", but the minimum standard is less than as set out in Cornerstone; Some of the units are redundant and need to be removed.

Q6 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?

Recertification could be done in house for 5 yrs, covering minimum standards, with external review 5 yrly.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

"Smooth" would depend on the proposal of "minimum Standard"

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 14, 2018 4:53:37 PM
Last Modified: Friday, September 14, 2018 5:18:00 PM
Time Spent: 00:24:22

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am alarmed that this is even thought about. The current colleges run extensive and cpmhrehensive programs without the need for this crazy new system. One of my American Colleagues is just preparing for his US test and agrees that this proposed system is totally unnecessary with our College based system. I have no concerns regarding any of my senior colleagues competence

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Not to implement any of them if there is a college based system. The ACEM now even includes cultural competence as well as clinical

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Absolutely. The Health system is in absolute crises and my senior colleagues are leaving in droves due to the stress. Burnout is rife. Currently there is no time to do our clinical work let alone introduce a totally unnecessary recertification program. The NZMC should have 1 focus at the moment-to make it easier to retain its current senior work force, not drive it away. A number have already expressed that they will simply go to Australia or retire a bit earlier as see no need for this. many can nt be bothered even replying to this server Monkey because hey feel it is a done deal. The NZMC will disregard this at their own peril.

Q4 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?

Continue the status quo of the respective colleges in continuing their current CPD program. I cannot find any evidence that current senior staff are unsafe and are risking patient safety yet the system proposes evidence based criteria

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

The ones that are currently mandatory (eg ACEM) are entirely satisfactory

Q6 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?

The current ACEM has peer review.What is the medical council thinking!!

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Why tinker with something that isn't broken. Burnout and its solutions should be a priority for the NZMC not cause it. NZ senior doctors are becoming very despondent with the current Health crisis and the NZMC should involved in the solutions, not adding to it. The system may be very easy to implement if there is no one to impose it on because because the work force has disappeared, particularly in the Public system.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 8:42:08 PM
Last Modified: Wednesday, October 31, 2018 9:10:31 PM
Time Spent: 00:28:22

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

we are already doing CPD for the college. we dont need to do extra CPD or pay more for recertification. gp college collates points over a 3yr process which is important for women going on maternity leave etc.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

keep things as they are, but for eg, peer group meeting hours could be reduced so we could add more points/add hours to reading articles that are relevant to our patient care etc.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

just dont make us waste more time doing extra CPD when we already do CPD for our college and increase fees/cost for recertification when we already pay enough for college/MCNZ/indemnity insurance fees. even part timers have to meet the same CPD points as full time workers. dont make life difficult for part time workers with young families when we are already short of time. Also I assume people who write literature are not busy seeing as many patients like we are, or looking after young families and sitting at their desk writing up articles.

Q4 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?

see above and you could pay us to attend all our medical conferences. and see above about colleges where we already provide a lot of CPD points like gp college. they can let you know if we are not meeting enough points rather than recertification.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

GP college already ask us to do enough, CMEs, peer groups, reading literature, audits etc.

Q6 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?

we already do peer group meetings and work peer meetings which is enough outside of seeing our patients.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

dont add more hours to our already extensive requirements for our college CPD/MOPS, and we also dont need more expenses. life is busy enough when you have a young family, providing care for them and your patients, and doing CPD on top of that.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Friday, 2 November 2018 11:23 a.m.
To: Strategic Consultation
Subject: Re certification

All doctors will agree and support a robust re certification programme Patients physical, mental and spiritual well being are the doctors mantra since the days of Hippocrates But it seems to me that the focus is based on the practices of full time doctors working from specific medical practices As a GP of many years experience in rural Wairoa, I now live in Napier and my practice is to help out in a number of various practices both locally and nationally, often for just a week or so at a time
50 hours, no problem & attendance at endorsed CME conferences as well as local Peer Review meetings is not difficult The difficulty with my type of practice is the one of practice audit when one is not working in any one practice for sufficient time to implement an audit of practice activity.
I suspect there will be many practitioners in a similar situation who need guidance on how they can fulfil the re certification requirements in a safe and manageable manner I look forward to your thoughts Kind regards [redacted] Sent from my iPad

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 10:27:28 AM
Last Modified:	Friday, September 07, 2018 10:32:38 AM
Time Spent:	00:05:10

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

It will be essential that the very different scopes of practice are taken into account when considering this. For example, the professional activities of a public health physician, a pathologist, or a radiologist, differ markedly from those of a physician or surgeon with regards to patient contact and service delivery. CME and CPD will be common components across all professions.

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**James Ussher**
Company	**Southern Community Laboratories**
Email Address	[redacted]

Q9 Your position/title:

Consultant Clinical Microbiologist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: Matthew Valentine <[redacted]>
Sent: Tuesday, 11 September 2018 11:09 a.m.
To: Strategic Consultation
Cc: asms@asms.org.nz
Subject: RE: MCNZ - Strengthening recertification - discussion document for feedback

Categories: Blue Category

Hello,

Nowhere in the document is there an actual problem statement. So the question remains, what current problem with recertification is MCNZ trying to solve? What is currently insufficient with the various colleges' requirements for recertification, which are being continuously revised and updated. Without any clear statement of a problem that can only be addressed by changing MCNZ guidelines, then no comment can really be made. The most logical conclusion then becomes that the purpose of the exercise is continued justification of this role for the MCNZ, rather than any actual improvement of clinical care in NZ.

I would prefer to see MCNZ putting more emphasis on who becomes a doctor than on the recertification process, as there is no identified problem with the way that specialty colleges handle the latter. On the other hand, for example, in my hospital we've been dealing with a protacted, painful, and expensive process (for all parties involved) regarding a PGY1 trainee, whom MCNZ was warned about by the university but did not act on that warning nor even pass it on to us. If this issue of who becomes a doctor were to be better managed, than the issue of recertification would be minor.

You mention other countries are reviewing and revising their recertification processes as well, among them the US. It is worth noticing that in the US, due to perceived overreach by various recertification agencies, there has been significant pushback from doctors. This is to the point of legislation being passed in some states to block the requirements. While this has generally been against the specialities themselves, rather than the state boards, the underlying issue is the continued growth cycle of reactive regulation to try to deal with isolated issues of clinicians who probably shouldn't have graduated medical school anyway, combined with certification agencies feeling a need to continually justify their existence and increase their power.

The expectations of SMOs in NZ, in both clinical and non-clinical domains, are steadily increasing. At the same time, the support and time for them to do these tasks is steadily decreasing. Yet nowhere in these papers do we ever see any discussion of making recertification easier or more streamlined. I would expect that the MCNZ would use my membership fees to that goal.

Regards,

Matthew Valentine, MD, FACEM, FACEP
Medical Lead, Whakatane Hospital
Clinical Director for Informatics, BOPDHB
[redacted]

From: Medical Council of New Zealand [mailto:sconsultation@mcnz.org.nz]
Sent: Thursday, 6 September 2018 16:18
To: Matthew Valentine
Subject: MCNZ - Strengthening recertification - discussion document for feedback

[redacted]

From: Strategic Consultation
Subject: FW: Strengthening recertification for vocationally-registered doctors in New Zealand

From: [redacted]
Sent: Friday, 2 November 2018 6:54 p.m.
To: Strategic Consultation <SConsultation@mcnz.org.nz>
Subject: Re: Strengthening recertification for vocationally-registered doctors in New Zealand

Hello Rachael

I also noticed that I didn't finish one of the sentences I wrote

"I understand that there will always be the need for a form of CPD program. But to believe that a CPD program will create better doctors, or stop some doctors from being `bad doctors` that end up causing damage to patients and"

the sentence stops there.

What I meant to say was " ...and ...end up in court or in the newspapers causing public concern and anxiety about GP`s fitness to practice, well that is probably and illusion.

I hope you can amend this prior to publication.

Yours Sincerely,

[redacted]

[redacted]

Sent: Thursday, 1 November 2018 11:35 p.m.
To: Strategic Consultation <SConsultation@mcnz.org.nz>
Subject: Strengthening recertification for vocationally-registered doctors in New Zealand

Hello,

I`ve decided to give you my honest point of view on re-certification programs for GP`s.

I suspect you will not like it, and it is not likely to be a popular point of view either, but I`m sure that more colleagues think the same without that they actually (dare to) express it.

[redacted]

To my impression, the main reason for CPD/MOPS/recertification programs in any country is that they are mostly a `political` tool`. It is a way for the Department of Health/Medical Council/Colleges to quantify and to provide proof to the public that they've done effort to `create good doctors`. You could even say it is a way to justify their own existence to the public eye.

Reality is that most GP`s I know already do everything that is described in this discussion document
" STRENGTHENING RECERTIFICATION FOR VOCATIONALLY-REGISTERED DOCTORS IN NEW ZEALAND"

and that is that the large majority of GPs I know are trying to be the best GP they can be - and they do this by analysing the various aspects of their every day practice, self reflection, and trying to improve things on a daily basis.

So I believe that most GPs do on a regular basis many more hours of research/training/self-reflection/ mini-practice-improvement-projects ... then what they declare in their annual MOPS

And all of this without it being enforced in RPRs or PDPs.

When being asked to `record` all these activities into the format requested for MOPS purposes - being it a PDP, PDSA learning cycle ..., I find this often takes considerable time - to the extend that it actually takes away considerable valuable time that I might otherwise spend on doing more CPD type activities.

In other words, the more I have to `record` CPD , the less CPD I actually end doing. I`m only doing more `on paper`.

I understand that there will always be the need for a form of CPD program. But to believe that a CPD program will create better doctors, or stop some doctors from being `bad doctors` that end up causing damage to patients and

I wonder if there is any evidence at all that an increase in compulsory CPD for GPs results in better health outcome for patients / less ACC treatment injuries/ less law suits and less suspended doctors / less (or more?) burn out,...

And with every change in the program we have seen an increase in requirements, without any significant evidence behind it - so I would be surprised if this new program won`t involve another few extra little tasks `that will only take a few hrs `

There may actually be a case for less compulsory CPD - or greater flexibility. Offering 10 different types of CPD and stating that each GP needs to do a min. number of hours of each of these 10 type activities may be many things, but it is not flexible.

Personally I think it does make sense that we do 3-annual CPR/ALS refreshers. And in New Zealand it makes perfect sense to have a refresher in cultural/Waitangi training every 3 yrs.

I find that peer review meetings/small learning groups meetings can be a most useful activity offering reflection and increase in knowledge on so many different levels of GP practice.

Apart from those activities it makes sense to obtain a certain number of `points` doing a range of activities that a GP chooses to fit his/her (patient`s) needs - but I believe flexibility would have a place here.

I think it should rather be the role of the College to `offer` all the various options of CPD such as PDP, RPR, CME activities, audits, ... and make recommendations, rather then enforcing them the way it is been done at present.

Yours Sincerely,

[redacted]

Collector: Web Link 1 (Web Link)
Started: Saturday, September 15, 2018 9:50:15 AM
Last Modified: Saturday, September 15, 2018 10:08:18 AM
Time Spent: 00:18:03
[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I do not support this. This approach will be very time consuming. We already do CPD/accreditation with our respective colleges. I happen to be board certified in the [redacted]The MCNZ proposed recertification approach will hinder medical care in New Zealand by making doctors spend extensive amounts of time forming further “portfolios”.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I believe the status quo is best. Let those with vocational registration continue to recert under the guidance of their repective colleges.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes - this proposal will force doctors to spend more non clinical time formulating portfolios and the

Q4 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?

Let the colleges do their own recert - maintain the status quo

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

College mandating recert processes.

Q6 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?

Institutionally we already engage in peer review. This is best left to individual organizations.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Please do not proceed. The status quo is best.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 4:24:48 PM
Last Modified: Wednesday, October 31, 2018 4:45:47 PM
Time Spent: 00:20:59

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Previous efforts of the bpac recertificaiton are tedious and do not tell anyone if the doctor involved is competant, and the process should be abolished as it a waste of taxpayer money and time

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Medical council approved workshops like surgical/anatomy courses for those surgically inclined, medical case discusses for future medics, specialty courses etc as needed. Both useful from a learning point of view and also adds to CV which will be usefull for further training applicaitons

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Political will within the members of the council. Current concepts are outdated and are seen by most doctors to be rubbish, as thy can be faked easily

Q4 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?

Mostly cost issues but the funding for setting up can be shared with the doctors, as it does directly benifit them as well

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. Mandatory recertification at its current point can be easily faked. self improvement should be self motivated, if current doctors choose not to attend workshops/training courses, it will reflect in their CV and their future employement

Q6 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?

RPR is probably the only useful part of the current bpac recertification program

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Other than the fact that our ideas will not be used? No

Page 2: Submission information

Q8 Your information:

Name	**Sam Verne**
Company	**Locum**
Email Address	[redacted]

Q9 Your position/title:

Registrar

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Sunday, 16 September 2018 2:12 p.m.
To: Strategic Consultation
Subject: survey

Categories: Blue Category

Hello,

I'm not sure of the point of the survey as it sounds as though decisions have already been made on the future course of action. We working physicians never know the full extent of the new requirements until they are fully being utilized.

If you asked me, there is no need to change anything. I already comply with the MCNZ, [redacted] requirements which take me many hours each year. This is time away from family, patients and hobbies.

They should focus on the bad apples. I know of one that continues to work despite ongoing issues for years.

Sincerely and respectfully,

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 8:05:49 AM
Last Modified: Friday, September 07, 2018 8:20:14 AM
Time Spent: 00:14:25

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Good; a sensible extension of current CPD

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Consider 3 yearly compulsory patient/whanau and colleague (including non medical colleagues) MSF

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

In many organisations including DHB's, support for time to undertake these activities is patchy at best, and how this is supported needs to be demonstrated by employers

Q4 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?

College and health systems involvement by SMOs needs to be recognised as contributing to doctors working at the top end of their scope of practice: without these supports the high trust model of recertification could well break down (an example is college work not being recognised as contributing to CPD/recertification)

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

As above, 3 yearly patient/whanau and collegial/multidisciplinary reflective feedback and a clear process for discussing/ensuring feedback is reflected on - the lack of ability/willingness to reflect on practice is one of the significant red flags for doctors practice

Q6 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?

The content and quality of reflective practice is key; need for some external framework (such as clear process for selecting patient cases for discussion at random, rather than only the cases a doctor wishes to bring)

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Requirement that employing organisations are explicit about how they support recertification; risk is otherwise that this may fall back on doctors in their own time without adequate support, meaning recertification becomes another burdensome, tick box excercise rather than a true opportunity to reflect on practice.

Page 2: Submission information

Q8 Your information:

Name	**Paul Vroegop**
Company	**Counties Manukau Health**
Email Address	[redacted]

Q9 Your position/title:

Psychiatrist and Pain Specialist, Clinical Leadership positions

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, October 29, 2018 11:46:19 AM
Last Modified:	Monday, October 29, 2018 11:58:30 AM
Time Spent:	00:12:11

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Overall good. Need to consider results from the Dr's own practice.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Unsure- marrying data with the Dr will need to be achieved through data analysis and the cost of this will vary depending on the size/capability of the organisation? Eg a small general practice may need the help of its PHO to analyse the Dr's data?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As above. I am also concerned about non-vocationally registered Drs working in general practice whose certification should be at least as robust.

Q4 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?

Cost of data analysis.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Audits of various sorts. I am particularly concerned about so-called "holistic" clinics who test and prescribe with a poor evidence base and how they can be regulated.

Q6 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?

Workforce, particularly in general practice where we don't have enough GPs already to see the actual patients.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Gradually increasing the percentage of RPR? Start with those Colleges/practices/Drs where there have been the most serious complaints?

Page 2: Submission information

Q8 Your information:

Name	**Dr Jenni Waddell**
Company	**Comprehensive Care PHO**
Email Address	[redacted]

Q9 Your position/title:

Clinical Director

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, September 11, 2018 3:59:16 PM
Last Modified:	Tuesday, September 11, 2018 4:08:04 PM
Time Spent:	00:08:47

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree that CPD activities should be more relevant to the doctor's scope of practice

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME

Q6 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?

My role is mainly administrative so the current system is irrelevant to me and my colleague. CME is important and peer meetings to a lesser extent but multisource and patient feedback asks irrelevant questions. We do not prescribe or see patients. In addition, we work in a crown enterprise where we are in regular contact with specialists so scheduled documented supervisory meetings are unecessary

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Dr. Debbie Walkden**
Company	**New Zealand Blood Service**
Email Address	[redacted]

Q9 Your position/title:

MOSS

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 17, 2018 10:26:54 AM
Last Modified: Monday, September 17, 2018 10:41:22 AM
Time Spent: 00:14:27

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I support these components in principle

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

This is for the Colleges to implement this through their CPD programs which are web based.IE the existing programs need to be adapted to the new proposals (eg making MSF a required component)

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

A vocationally registered doctor who is in a non clinical role (for example Director of Clinical Training for a DHB - role that requires the incumbent to be vocationally registered and hold an APC). This is a situation which may occur when a vocationally registered doctor is in the twilight of his/her carrer and still wishes to contribute but in a non clinical role.

Q4 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?

No. The processes are already in place. They just need to be adapted to comply with the new proposals.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

1.Active participation in CME activities such as Grand rounds, Mortality and Morbidity meetings, Multidisciplinary meetings and conferences relevant to their current role. 2. Multisource feedback - this will guide future learning.

Q6 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?

No issues. Mulitsource feedback is an evidenced based process.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**Ian Wallace**
Company	**Waitemata DHB**
Email Address	[redacted]

Q9 Your position/title:

Director of Clinical Training (no longer active in clinical practice - retired)

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: William Wallis [redacted]
Sent: Monday, 24 September 2018 9:43 p.m.
To: Strategic Consultation
Subject: re Towards strengthening recertification requirements for vocationally-registered doctors in New Zealand

Categories: Blue Category

Dear Madam or Sir,
My only comment is that the NZMC should stay out of adding their agenda upon specialist colleges' recertification requirements. The colleges are the only bodies that have the appropriate expertise to monitor their specialists' competence and continuing maintenance of professional standards. I appreciate that this may not apply to some groups of doctors but as a fellow of the RACP my opinion is that there is no one on the MZMC qualified to impose additional requirements on specialist and general physicians, such as so-called "cultural competence" and so on. It already takes enough time to fulfil our recertification without adding more burdens that have no proven value to improve our competence
William Wallis
[redacted]

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Monday, September 17, 2018 5:45:38 PM
Last Modified:	Monday, September 17, 2018 6:02:21 PM
Time Spent:	00:16:42

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think non clinical research work and teaching should be exempt from the strict guidelines

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Making things too rigid and hard will mean a lot of valuable experience and knowledge won't be able to be utilised

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Audits and peer review are difficult in non clinical practice

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Continuing evidence of medical education and collegial review

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, September 09, 2018 8:51:28 PM
Last Modified:	Sunday, September 09, 2018 9:09:36 PM
Time Spent:	00:18:08

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

agree but need to allow for people like myself who are registered in a General scope but working in a Speciality such as Emergency Medicine

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

5 yearly formal exam?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes, dealing with alternative medicine practitioners who should not be able to claim credits for attending courses based on delusional belief systems

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Collegial behaviour

Q6 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?

Simulated emergencies work well in EM

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

All changes should be audited to assess value and effectiveness

Page 2: Submission information

Q8 Your information:

Name	**John Welch**
Company	**NMDHB**
Email Address	[redacted]

Q9 Your position/title:

Dr SMO

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:37:26 AM
Last Modified: Friday, September 07, 2018 9:53:54 AM
Time Spent: 00:16:27

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

If I understand the approach correctly the NZMC sets expectations and seeks cooperation from specialist colleges to incorporate these into their CPD programmes. If that is correct I agree with it. What I wouldn't agree with is a duplication of activities to peer CPD and peer review.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Recertification programmes need to be led by professional bodies with specialist subject knowledge. Again, utilising the colleges to develop programmes to incorporate activities that examine evidence-based practice would be good. I think workshops for practitioners particularly targeted to areas where "gaps" are likely for a large number of practitionrs would be of benefit.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The main challenge I see id bringing people on board so it is not viewed as "extra (unnecessary) work", but as a useful path to individual performance improvement.Secondly, none of the CPD activities I have been involved in ever identify under-performers. It would be nice to have a process for that in place.

Q4 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?

Colleges will, at some point, need to interact more closly with their fellows. Some colleges, based in Australian, are very Australian focussed and have sub-standard representation in and from NZ.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

If practice changes significantly within a vocational field, e.g new technology emerges which requires skills not covered by most practitioners, then training workshops to become proficient should be mandatory.

Q6 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?

At present the recertification provided by my college is marginally sufficient. It needs to focus on emerging new ways to practice and hasn't done that yet. Agan, I like the workshop based certification as it is very time-circumscribed, it is small group learning and the "teacher" should be able to assess adaequately whether e person can be certified or not (which is the important bit - what happens if someone lacks the skill????)

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Anja Werno**
Company	**Canterbury Health Laboratories**
Email Address	[redacted]

Q9 Your position/title:

Chief of Pathology & Laboratories

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, November 04, 2018 9:19:00 AM
Last Modified: Sunday, November 04, 2018 9:25:20 AM
Time Spent: 00:06:19
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Evidence based

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

We are trying to facilitate regional RPR in Top of South

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Change management

Q4 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?

Funding for RPR collegial visits

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

RPR visit,audits,PDP,MSF

Q6 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?

Funding for Pegasus small group education programme

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Nil ar this stage

Page 2: Submission information

Q8 Your information:

Name	**Neil Whittaker**
Company	**GP**
Email Address	[redacted]

Q9 Your position/title:

CME FACILITATOR

Q10 This submission is on behalf of: **Group**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

From: [redacted]
Sent: Tuesday, 20 November 2018 10:12 p.m.
To: Strategic Consultation
Subject: Re: MCNZ - Strengthening recertification for vocationally-registered doctors

The proposal about recertification seems very similar to what we currently do and is really important way to ensure that we keep up our professional standards. I agree with the proposal. It is a very good general document to ensure we keep up to date.

Some brief comments though in relation to areas that may find more difficult to fully participate in.
1) Country GP's will find some of this harder to complete as there are only limited ways to get peer review feedback , or even get education modules (like the pegasus education groups), . Possibly more needs to happen with "skype type" groups for education
.
2)Semiretired GP's find the PDP concept difficult. As an older GP doing just locums and other doctors who have been in practice a long time doing a PDP seems less relevant. We tend to learn more by current problems that occur in the daily consultation rather than planning to improve over a year for a specific deficiency. Obviously the core emergency updates are very important but this is a given and not part of the PDP.

If a PDP and audit is to be relevant to the older GP then it needs to reflect the nature of incidental education and the way one is currently practicing. . Audits are more difficult if moving practices all the time as there are only so many times one can do a note review, ask for feedback from staff re communication, or feedback from patients . It is more by doing on line learning and checking that one is following current practice. Health Pathways has made this much easier to check guidelines for any particular problem. Not sure if there is any way that the PDP could be more relevant.in the older age group . I realise that there is concern about older doctors and yet years of experience is incredibly important and so therefore ongoing education and learning needs to be relevant for us..

Peer groups are essential and incredibly supportive and help in keeping doctors with relevant information. This has been the biggest help in changing my practice and supporting me over the years.

The other relevant activity was having supervision by a registered Psychologist and could possibly be something that is recommended to all doctors as it helps one become aware of the issues that can arise in communication and how to develop those skills..

[redacted]

On Wed, Oct 31, 2018 at 9:01 AM Medical Council of New Zealand <sconsultation@mcnz.org.nz> wrote:

Dear Colleague,

For a number of years now, the Medical Council of New Zealand (Council) has been working towards strengthening how we ensure doctors practising in this country are up to date and continue on the path of lifelong learning.

Recertification is a process that gives assurance to Council, medical colleges, and most of all to members of the public, that doctors are undertaking activities to ensure they remain up to date and provide opportunities for continued professional development.

You may be aware that Council has been consulting on recertification. The current discussion document, which is out now for feedback, is the culmination of extensive consideration, discussion and research. It provides context of where we have come from, what the evidence tells us about what works (including a literature review undertaken to consider this), and proposals for where we could go next.

I would encourage you to read the newsletter which contains further information around recertification at the link below. You can also find further information about the consultation on Council's website.

- *Newsletter for the profession on recertification*
- Consultation page on Council's website

I believe for most of us, Recertification will be very similar to our current CPD, but it is important Council has your feedback. If you haven't already given us feedback, I hope you can find the time to do so.

Yours sincerely

Andrew Connolly
Chairman
Medical Council of New Zealand

If you are having trouble viewing this email follow this link.

Important information about unsubscribing: Please read this information if you are considering unsubscribing: The unsubscribe system offers an option to unsubscribe from 'all future communications from Medical Council of New Zealand'. Under the Unsolicited Electronic Messages Act 2007, selecting this option prevents us from sending you any emails and could means that we may be unable to send you important information via email in the future. Please do not use unsubscribe if:

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[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 25, 2018 5:28:54 PM
Last Modified: Tuesday, September 25, 2018 5:34:45 PM
Time Spent: 00:05:50

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Overall not necessary as current system established and largely covers/overlaps proposals. Cumbersome and onerous on top of already gruelling requirements

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Not neceassary; largely covered already

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Lack of time and energy

Q4 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?

College of GPs is doing fine thanks

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

As prescribed by College of GPs for GPs, can't speak for other specialities

Q6 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?

Current peer review adequate

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Leave GPs alone

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:34:04 PM
Last Modified: Thursday, September 06, 2018 9:39:35 PM
Time Spent: 00:05:30
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Not necessary; current process satisfactory for GPs

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

None

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Lack of faith that even more and more difficult requirements will be imposed on top of the already onerous 50+ hrs

Q4 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?

Leave the system alone

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

As currently required

Q6 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 currently practiced

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Avoid revolution

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Saturday, November 10, 2018 3:04:46 PM
Last Modified:	Saturday, November 10, 2018 3:52:17 PM
Time Spent:	00:47:31
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Well meaning but I've seen it before and you spend 80% of you time proving you've learnt something which could have been spent learning some thing ne and is an incredible waste of time. Also the regulators keep adding a little bit more all the time and make it a complex, bureaucratic and unworkable monster. COI ex-UK GP.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Decisions about what should be done needs to be made by our peers. KEEP IT SIMPLE. KEEP IT FORMATIVE. the temptation is to use it as a means of regulation, once you do that it is game over and it stops being educational and everybody clams up and becomes defensive.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes, a huge amount of mistrust. Most UK GPs have seen it go disastrously wrong in the UK and will be suspicious. There is a serious danger of creating a bureaucratic workload that will make older GPs head for the exit. You can not afford that to happen. It must be simple and easy for normal GPs doing their normal CPD to do without difficulty.

Q4 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?

Who decides what is needed for each person. I use a lot of IT at home and at work and build servers for a hobby but cannot learn from combuter based learning as it is non-interactive and I am not an AV learner though looking at me from a distance you would think I was. How do we determine how doctors are to learn.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No doctors roles are so variable that you cannot create a one size fits all.

Q6 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?

I work as a locum permanently. The PHO wanted me to sign a contract with them but I declined as I read it and was unable to meet the terms and conditions stipulated. I rewrote it for them to one I could sign but they did not get back to me presumably because it was not acceptable for them. What problems can you foresee for me?

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

You need to consider carefully all the different roles that doctors have and how they interact with all the different organisations before introduccing a regulatory framework. This was not done in the UK and they lost a shedload of doctors and are still losing them (15% vacancy rate in General Practice at the last count and losing 100 FTE a month). Don't forget Missionaries abroad. They did in the Uk. How do they do this. Lots of different Drs have to comply with this framework in all sorts of situations and if you get it wrong, patients in all sorts of situations suffer as they lose doctors. We work in all sorts of funny situations.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, October 02, 2018 4:56:55 PM
Last Modified: Tuesday, October 02, 2018 5:07:16 PM
Time Spent: 00:10:20
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

It will add to administrative burden and there will need to be infrastructural support to enable robust MSF and regular practice reviews. MSF requires many participants and with every doctor requiring such ? annually? three yearly, then our colleagues are going to be exhausted filling out all these forms. having said that, MSF is very powerful when done well. There are challenges with practice review - costly, timeconsuming, more challenging for the non procedural specialities where outcome data harder to be confident about.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

perhaps some guidance on the key elements e.g. what do you envisage by the scope of regular practice review, how many observers for the MSF, what is the standard for each?

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes - cost and time, clinician acceptance,

Q4 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?

The sheer cost of regular practice review - who is going to do all these reviews? it is very time consuming. Who is going to provide training for such. How will we ensure MSF is robust? We know our colleagues hate providing negative feedback even if constructive. Anonymity does not always mean honnest feedback will be provided.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

in principle MSF if we can get it well established and be certain about the quality. Engagement in peer review activities such as MDMs, case reviews, mortality meetings, quality asssurance activities. Better than simple audits as the quality of those varies.

Q6 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?

Multidisciplinary case discussions, external peers can provide additional perspectives, involvement in quality assurance activities and service improvement (requires review of best practice), benchmarking where applicable

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

proceed slowly

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

From: [redacted]
Sent: Wednesday, 31 October 2018 10:21 a.m.
To: Strategic Consultation
Subject: Recertification newsletter

Dear Carol,

Thank-you for this work, which I am sure will be of real benefit to the public and the profession. Unfortunately, currently, there are too many abbreviations that I don't understand, in this newsletter, and for me, this limits my understanding of the proposal significantly

[redacted]

[redacted]

From: [redacted]
Sent: Friday, 7 September 2018 12:23 p.m.
To: Strategic Consultation
Cc: [redacted]
Subject: Peer review

Categories: Blue Category

The document is well done I suppose.

However there has been ongoing failure over the last 15 years to assign a proper CPD programme for those doctors without any specialist qualifications who quite happily present themseves to the public as specialists.

I refer to the rise in particular regarding those who tout themselves as skin specialists.

What CPD programme do they work under?
Certainly not the dermatologist programme, nor plastics or general surgery.

They should develop their own CPD appropriate for the area of medicine they practise in.

I await your reply with interest.

[redacted]

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 9:43:36 AM
Last Modified: Wednesday, October 31, 2018 9:50:30 AM
Time Spent: 00:06:54
[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Agree with process and majority of content. I am concerned at how onerous the process may become.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Need greater details of actual requirements. Broad overviews lacks sufficient information to actually make a detailed appraisal.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Heaps. [redacted] ANZCA has a very robust and extensive CPD package. Your package in addition feels like I am completing two CPD portfolios with different requirements in parallel. Ie if I meet the needs of ANZCA for reaccreditation, why do I need to do a heap of different things to meet medical council recertification. The cost and time involved may be difficult to justify.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Very dependent on practice and environment practicing in.

Q6 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?

This is costly and has huge implications on time and availability of staff to perform this role.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

You need to give actual examples for particular types of docs. Ie one for a GP, one for a doc who is now an administrator, surgeon in public, surgeon in private practice.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 11:02:30 AM
Last Modified: Wednesday, October 31, 2018 11:45:16 AM
Time Spent: 00:42:46

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The key components are to ensure the doctor is doing a proper job at consultation.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Already, the NZ Roylal College has been imposing a MOPS programme since early 1980 that includes multiple activities including attendance of medical seminars, Peer review, per so nal deveoplment, audit of the practice,community health activities etc.In addition to Cornerstone programme, all these are to improve & ensure the standard of medical & health care. These takes a lot of time outside the practice time. Any more similar activities will hardly leave any more time for the family and the doctor himself/herself. This will discourage younger doctors to take up general practice.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The other way is to visit the practice and read the clinical notes of t he practice. However, this will invlove employment of many qualified doctors to do this & cost a lot of time and huge amount of money.

Q4 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?

As mentioned previously, MOPS & Cornerstone progr amme would be adequate; other additional programme will cost a lot of time for the practsing doctor & a lot of money and man power to run an additional programme by the Medical Council.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

It appears that at present, the practising general practitioner has to complete the MOPS programme before the annual registration.

Q6 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?

In the MOPS programme, it is required to record the discussion of cases each time. T he medical seminars are recorded too t hat would update the medical recent advances.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I think the MOPS & Cornerstone are adequate at present.

Page 2: Submission information

Q8 Your information:

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 10:27:07 AM
Last Modified: Monday, September 10, 2018 10:47:14 AM
Time Spent: 00:20:07
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Recertification should not cost the doctor more time than it does already. Should include the things that we do everyday, not "extra" study to revisit the "zebra" topics which we never see. We have enough paperwork already that takes us away from our patients and family.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

We need computer software which is integrated into our current record keeping systems which would facilitate the recertification process. Much of what we do is included in the recert but is not easily retrieved from our current records.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As above

Q4 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?

Update the electronic record keeping

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

CME!

Q6 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?

peer review should be sealed documents and unavailable to any legal investigations. If I know what I say or write about a collegue may be used in court, I will be reluctant to be honest as all times.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Sunday, September 09, 2018 4:25:18 PM
Last Modified: Sunday, September 09, 2018 4:44:19 PM
Time Spent: 00:19:00
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

No particular comment and agree should be patient focussed

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

HQSNZ survey is a bit of a beast and not user friendly. Need to sharpen it up and ensure efficacy across cultures

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Ensure relevant for practitioners within the same speciality but working in different areas geographically . The requirement is the west coast not comparable with Auckland.

Q4 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?

This is a pretty braid brushstrokes document , learnings from the UK experience in how not to make an awful administrative nightmare of a system that drives people out of the profession would be a good start

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Usual cpr updates as currently . IT updats and where going would be appropriate given the speed of change

Q6 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?

Need to ensure access for remote practitioners and that they are better supportd than their urban counterparts due to ease of attendance at face to face meetings

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

INCOMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:22:32 PM
Last Modified: Thursday, September 06, 2018 5:47:25 PM
Time Spent: 00:24:53

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Focus on outcomes such as continued engagement & stimulation, rather than politically correct, generic, placatory musings & veiled goals of keeping control.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Get feedback from practitioners who have recertified in the systems you seem to be working towards. There are good and bad elements, and there are elements that get “worked around” because they are not realistic. Remember this should be an improvement process.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The enthusiastic & interested will engage, but these systems often fail to identify those who just go through the motions

Q4 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?

No. The colleges usually do quite well

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. Better to provide a range of expectations for the individual to follow

Q6 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 above.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

See above answers.

Page 2: Submission information

Q8 Your information: **Respondent skipped this question**

Q9 Your position/title: **Respondent skipped this question**

Q10 This submission is on behalf of: **Respondent skipped this question**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, September 09, 2018 6:22:58 PM
Last Modified:	Sunday, September 09, 2018 6:27:50 PM
Time Spent:	00:04:51

[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

No more than what we have done now.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

No changes

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

More paper work , rather than focus on Patients.

Q4 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?

No changes

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No.

Q6 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?

Our current Peer review group has been since 1998. I am happy about this.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 8:13:39 AM
Last Modified: Monday, September 10, 2018 8:31:45 AM
Time Spent: 00:18:05
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Other than the practice visit, I already do all of these components.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I don't believe they should.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The practice visit sounds expensive and time consuming. According to your surveys, just over 1/2 thought they were helpful.

Q4 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?

No.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Staying current with the literature and perhaps an audit.

Q6 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?

Should be optional.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 12:21:40 PM
Last Modified: Monday, September 10, 2018 12:28:08 PM
Time Spent: 00:06:28
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Looks like a normal process for any other member of staff and should also be the case for doctors

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

The time commitments and cost involved will need to be discussed with the employers/ DHBs

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time and financial commitment for additional planing and learning

Q4 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?

N/A

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

The doctors would be best placed to set up their peer review meetings

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Take int account Knowles theories of adult learning - this looks aligned but there may be some additional thinking that comes from reviewing this longstanding taxonomy

Page 2: Submission information

Q8 Your information:

Name	**N/A**
Company	**xx**
Email Address	**xx**

Q9 Your position/title:

N/A

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 2:16:00 PM
Last Modified: Monday, September 10, 2018 2:21:48 PM
Time Spent: 00:05:48
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

My opinion is that this detracts from the purpose of the MCNZ that is taking on the PDP's of the various Colleges.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Perhaps the MCNZ should leave the actual accreditation to the Colleges

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

The MCNZ is repeating the work of the Colleges. Check in on the operations that the College do with infdividual Fellows but do not repeat it. Otherwise it becomes a meaningless, repetitive process.

Q4 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?

The re-certification is very person specific. Perhaps having colleagues of a doctor complete a reference on the person every couple of years could be a way to check on how people operate. The ones who we do not hear from are the ones to be worried about.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no

Q6 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?

Regular meetings and allowing Doctors time off to take part in activities is the way to go.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

The MCNZ needs to go back to doing its core work

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 5:37:27 PM
Last Modified: Monday, September 10, 2018 5:50:18 PM
Time Spent: 00:12:51
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

whilst a good attempt to strengthen the messages about recertification, this is an opportunity for the Council to make advances to the approach rather than play 'catch up'. the document seems to suggest that the Council is trying to catch up with some other and better processes. this is an opportunity to lead the process - lets not miss it.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

1. there is no mention of meeting behavioral requirements. there is enough evidence, including from the ASMS surveys that bullying, harrassment and poor behaviour continues to plague the medical workforce. the document does not set the parameters while we have an opportunity.2. one of the key messages of the annual planning processes released by MoH outline, as an example the need to keep language patient friendly. the recertification process needs to align with nationaal requirements. at this stage, it seems divorced from national requirements. 3. there seems to be no requirement or obligation to interlink with other professional groups. Medicine has long remained an isolated profession, it needs to embrace other professional groups and build that into its processes. 4. the process is silent on the formal need to reserach. research is an integral and very important part of progression and again, there seems to an opportunity missed, if we were to remain silent about it.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

there are always challenges associated with change. however, if we know we are doing it for a better and more committed medical workforce, this should be easy to sell. reserach and other obligations will draw changes to the terms of employment and mean a reduction in clinical time, but the overall benefits, to the individual, organisation and to patients far out weigh these challenges.

Q4 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?

more emphasis towards building values and behaviours within teaching curricula is important. communication and respect is vital if the Medical workforce has to maintain or return to its position of being perhaps the most vital resource to humankind. review the curricula to include research.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

as mentioned earlier.

Q6 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?	**Respondent skipped this question**
Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?	**Respondent skipped this question**

Page 2: Submission information

Q8 Your information:

Name	**xx**
Company	**xx**
Email Address	**xx**

Q9 Your position/title:

xx

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Monday, September 10, 2018 10:23:25 PM
Last Modified: Monday, September 10, 2018 10:50:38 PM
Time Spent: 00:27:13
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I like the components especially trying to base it on evidence. I'm not happy with component seven though (see below)

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

We need funding.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes there would be several challenges in my area of general practice. We have a large number of groups with their own interests pushing us to do more and more, yet the funding doesn't follow. This will be yet another thing (while great) without any funding which is very disappointing. Placing the cost burden on the employer is unfair. General practice is partially government funded so there should be some funding for this for each GP. A further concern is that we have very limited resources for learning. We do not have access to major medical journals and point of care tools e.g. uptodate like our hospital colleagues. Without access to quality learning materials, any recertification process is MUCH less useful. The council should force the college to fund this for us. There are some european countries like Norway that fund this for ALL citizens, so it can't be that hard.

Q4 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?

I would like to see the MCNZ require the GP college provide equity with regards to learning materials that our hospital colleagues get.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I think there should be a diagnostic/clinical reasoning component, because medical errors are a leading cause of morbidity.

Q6 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?

Lack of funding is the main problem (point 7). Capitation is not keeping up with medical inflation, and we have government approved anti-competitive VLCA practices, plus cornerstone accreditation which costs tens of thousands of dollars in work hours and fees. Many practices are at breaking point. Funding funding funding!

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Bottom line is that I like the idea for my area of general practice but we need funding and access to learning resources.

Page 2: Submission information

Q8 Your information:

Name	**Dr Anonymous**
Company	**Anonymous**
Email Address	**anonymous**

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 13, 2018 10:25:47 AM
Last Modified: Thursday, September 13, 2018 10:30:49 AM
Time Spent: 00:05:01
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I don't understand what the document is about - we are all doing this anyway.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think that we do enough.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I think we are all working hard and this is an email that came and probably a lot of people are not going to pay much attention to.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Can you actually email us and in plain English let us know what you are actually proposing to change?

Page 2: Submission information

Q8 Your information:

Name	**Anonymous**
Company	**DHB**
Email Address	**a**

Q9 Your position/title:

Doctor

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, September 19, 2018 9:55:54 AM
Last Modified: Wednesday, September 19, 2018 10:11:14 AM
Time Spent: 00:15:19
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Individual designed prgrammes sound good

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Everyone one leans in different ways, so should all components apply to all people.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Objectives change with age - and education needs - but accreditation does not

Q4 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?

There is a feeling that the colleges are ivory towers and only connected to a minority of GPs

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Good post grad courses - I personally find the set up of Acurity in Wellington excellent. Short sharp and to the point.

Q6 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?

Local - but peer review is happening every day within our practice.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Lissen to the feedback and do not just dismiss it

Page 2: Submission information

Q8 Your information:

Name	**xxx**
Company	**xxx**
Email Address	**xx@eee.xx**

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 20, 2018 10:59:00 PM
Last Modified: Thursday, September 20, 2018 11:04:43 PM
Time Spent: 00:05:42
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Overly bureaucratic

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Colleges already have re-certification processes - therefore avoid overlap

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Colleges already have re-certification processes

Q4 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?

Possibly as most are Australasian, this may be at odds with a NZMC approach

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Peer review meetings are helpful

Q6 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?

Peer review already occurs across both colleges I work for

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Recognition of health informatics time seems important. It is an important activity within a developing scope

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 25, 2018 10:56:22 PM
Last Modified: Tuesday, September 25, 2018 11:25:40 PM
Time Spent: 00:29:18
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

How will this help me to deliver more effective healthcare more easily? If you're a good doctor you're being punished, they seem to be more about mandatory minimum standards. The PDP in particular is a waste of time.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

PDP plans rarely cover the interesting, relevant, important learning outcomes. If I look back on what I thought I'd learn 12 months ago versus what I learned, there is a huge difference, and that can't be planned for in advance, unless the goals are sufficiently vague as to not mean anything. People have a fair idea what they're good and and what they're bad at, all this paperwork sucks the joy from the work. We want to deal with patients and help them not fill in more forms! The goals themselves are not bad otherwise, but I just don't see them actually adding anything that is of more valuable that the several hours it will cost me to fill out this paperwork! Plus the costs of a doctor to visit will just mean more fees to the RNZCGP - these are not cheap and the value derived from them is not necessarily high.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Meetings with our colleagues or with a supervising or advising doctor happen regularly in the semi-structured environment that is general practice (unless you're working in a sole-GP practice) and therefore mandating regular meetings that you then have to keep a record of is just another annoying thing to have to do. Yes we do it, we seek help where needed, but do we have to write about it every time we discuss anything? If a tree falls in the forest and no one write any medical notes on it did it happen? C'mon! The main complaint about general practice is the paperwork and ever-increasing list of tasks that are palmed off to the GPs! Ways to REDUCE this should be a priority!

Q4 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?

Depends which aspect, if you are advocating more in practice visits then costs are the main one, this takes time and money, and I will be expected to pay for it. This is effectively a pay cut just so I can have someone watch me talk to patients for a few hours, half of whom will say no to someone sitting in, then they'll say that's all great carry on. Who benefits here? Specific concerns for recertification providers: liaising with the GP college is already a bit difficult. It is not clear to me what it is that the medical council sees as the main problem, and how that this should be improved, and then what EVIDENCE there is that doctors are failing in some way and what EVIDENCE is there that the addition of more certification is going to improve things. Sure, there is perhaps evidence that those who engage with recertification are better doctors, but correlation is not causation and it is likely that doctors who engage voluntarily or to a high degree with these requirements are more conscientious. If there is no evidence for it but it makes sense, sure that can be ok too, but the medical council should not make changes for the sake of making changes. Having medical colleagues in charge of recertification is the only way it could be run. But this should be coming from a genuine need from doctors not just the medical council, greater engagement with the doctors who will be affected is essential.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

annual practicing certificate. If you're vocationally registered then you've not got there by accident. This is by and large a highly responsible group of people, so let's not focus on minimum standards and making everyone meet them, lets focus on EVIDENCE based approaches that will help everyone without taking up huge resources. Otherwise no, I do heaps of learning about medicine, and making it mandatory to fill out a form about what learning I did six months ago is not helping anyone.

Q6 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?

Regular peer review is a fun and rewarding way to discuss interesting and thought provoking cases with your colleagues. It is best when it is semi-structured, lighthearted, sharing food also, allows adequate time, is paid for (not on my hours 'off work'). Should be held on site during work hours, maximum allocated time 45 min (nice and short), with everyone getting a turn to speak. These things tend to be dominated by the oldest male in the room in my experience. Making me do extra tasks outside of work hours when I am exhausted and having to miss out on family time, friend time, dinner, sleep time etc - these things are not helpful nor healthy. We should be promoting health of our doctors first and foremost.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

It sounds like a foregone conclusion at this point, but it doesn't need to be - there is still time to reduce the range of changes. Less is more.

Page 2: Submission information

Q8 Your information:

Name	**GP**
Company	**GP**
Email Address	**GP**

Q9 Your position/title:

gp

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, October 19, 2018 8:55:14 AM
Last Modified: Friday, October 19, 2018 1:02:07 PM
Time Spent: 04:06:53
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

seems to be adding more auditing of practice that is likely to add little to the existing but more time and work and focus away from patien care and more on processes and procedure

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I'm thinking other vested interest parties are influencing the re-certification eg multisourse feedback groups auditor organizations

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes the more focus reporting audits etc will distract from core patient care. Over self focus will do little to enhance patient care. Subjective appraisals influence by all kinds of bias. Little will be achieved in all this that will enhance trust in the profession. The more we go down the line of trying to show competency the more it will be doubted. The distraction of engaging in all this will take us further from the core business of patient care

Q4 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?

They are self selected and fit a profile focused on fault finding and many of their own biases.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

This too is very group dependent. The good ones are now very hard to get into. They determined by the individuals in them and like all human groups subject to all the complex interactions postive and negative

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I've tried to get collegues to give feedback but the overall response is that it is all a waste of their time. Consultation is only lip service and we are powerless to effect what is decided to be imposed on us. This will all be apparent when its too late.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of:	**Individual**
Q11 I wish my submission to remain anonymous	**Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Wednesday, October 31, 2018 9:10:30 AM
Last Modified:	Wednesday, October 31, 2018 9:11:14 AM
Time Spent:	00:00:43
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They will not lead to a great deal of change

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Respondent skipped this question

Q9 Your position/title:

Respondent skipped this question

Q10 This submission is on behalf of: **Respondent skipped this question**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 9:22:18 AM
Last Modified: Wednesday, October 31, 2018 9:36:32 AM
Time Spent: 00:14:14
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

seems comprehensive.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

time is always short and I am always doign these things in my own time. It adds stress. These requirements need to be a light as possible! I'm really mentally tired from the efforts of paperwork and electronic entering just to document and explain what I have done.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

it has gaps

Q4 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?

Apart from my vocational registration in pathology, I work in clinical trials doing medical assessments. There is no College for this in Australasia. I havent found an appropriate- not for profit- type institution anywhere else either. Can we start a new College??

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes

Q6 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?

regular meetings with colleagues are the most productive for me, in teerms of time efficiency and productivity..

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

it needs loads of time for people to adapt.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 10:17:21 AM
Last Modified: Wednesday, October 31, 2018 10:22:34 AM
Time Spent: 00:05:12
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

They sound worthy but will they lead to more "jumping through the hoops" components to reaccreditation?

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Should look at they important areas, not just those that are easy to measure

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Time, cost extra workforce to implement.

Q4 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?

See 3

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Understanding legal requirements. Otherwise The breadth of medical practice means there isn't much else that the practitioners have in common.

Q6 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?

No

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I doubt if implementation can be smooth.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 1:47:00 PM
Last Modified: Wednesday, October 31, 2018 1:54:49 PM
Time Spent: 00:07:49
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think that so long as the doctor is keeping up with their College' Continuing Professional Development scheme, then recertification is not needed

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I think it should be linked to pre-exisiting CPD schemes

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. Duplication of paperwork already being submitted to the Colleges CPD scheme

Q4 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?

I dont know. I suggest speak to the Colleges

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I do not think that audit should be mandatory. Often audits are done for 'audits' sake, as it is a requirment of CPD scheme, rather than resulting in ACTUAL Quality improvement

Q6 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?

No

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**I wish to remain anonymous**
Company	**.**
Email Address	**.**

Q9 Your position/title:

I wish to remain anonymous

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Wednesday, October 31, 2018 3:21:43 PM
Last Modified: Wednesday, October 31, 2018 3:31:40 PM
Time Spent: 00:09:56
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

More Pointless and excessive bureaucracy that will not achieve the desired outcome

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

not by compulsion

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes the entire system will collapse I can see a lot of very experienced doctors who are perfectly adequate who now have the financial resources to retire early will retire early rather than jump through these insulting hoops- effectively loosing 8-10 years of full time work from each from the workforce further accelerating the workforce collapse that is already predicted

Q4 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?

Access and cost - It costs a lot of time and achieves nothing it is just another pointless task added to what we already do just increasing desire to exit

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

minimal skill related standards

Q6 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?

They will force there own agenda and dogma on any one involved

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

realize that you are part of the problem not the solution

Page 2: Submission information

Q8 Your information:

Name	**No way**
Company	**annonymous**
Email Address	**no@xtra.co.nz**

Q9 Your position/title:

34 year GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, November 01, 2018 12:34:39 PM
Last Modified: Thursday, November 01, 2018 12:42:11 PM
Time Spent: 00:07:32
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I agree with them

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Guidelines on audits, quidelines and options on how RPR could be performed, mandatory 360 degree feedback, agree wthe the percentage apporach for different categories

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Who will provide the RPR - your colleague from same speciality/other specialty, confidence/skill of fellows to provide RPR, time for fellows to be engaged in providing RPR for each other.

Q4 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?

Having the skill/knowledge to provide appropriate guidelines for RPR and, less complex, audit.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

360 degree feedback and RPR

Q6 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?

Colleague review clinic letters, colleague sit in on a clinic, colleague follow a ward round. Issues already stated above.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Giving adequte lead time for providers to provide guidelines and then educate fellows in the skills required to be involved in RPR.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, November 02, 2018 2:30:00 PM
Last Modified: Friday, November 02, 2018 2:35:24 PM
Time Spent: 00:05:24
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I already do the audits as part of my College requirements. They are generally derided by all my colleagues as utterly unscientific and pointless. The number of patients treated, the wide parameters of such patients make any scientific or ogical conclusion impossible. The audit is pointless waffle.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Audit - drop it. Peer review is just a talk fest. CME hours are about right.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

None.

Q4 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?

The Colleges just struggle to find a practical way to fulfill these obligations without worrying about the value of the process.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

English language?

Q6 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?

Is this another way to raise College fees?

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Smooth implementation not smooth value. Carry on chaps.

Page 2: Submission information

Q8 Your information:

Name	.
Company	.
Email Address	.

Q9 Your position/title:

SMO Full time public

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Sunday, November 04, 2018 7:41:20 PM
Last Modified:	Sunday, November 04, 2018 7:47:50 PM
Time Spent:	00:06:30
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Very bureaucratic

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Needs to be more physician led, rather than dictated to the physician

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

It is a complete rehash of previous UK model which didn't work. Also MSF is not good if a physician is doing their job right because being independent assessor means that clients don't always like what they hear - e.g. that they need to take ownership of their position, that they need to engage with therapy to start to improve, that they will get better so return to work rather than receiving benefits is

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Cultural sensitivity course, basic life support

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**Me**
Company	**My employer**
Email Address	**me@myemployerscompany.co.nz**

Q9 Your position/title:

My job title

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

INCOMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:58:19 PM
Last Modified: Thursday, September 06, 2018 6:01:43 PM
Time Spent: 00:03:24
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

USA all over again. ABIM all over again.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

It will cast more money and be burdensome.

Q4 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?

Don't do it.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No.

Q6 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?

Could become a witch hunt.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't do it.

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

Verbal submission

Anonymous feedback received Friday 16 Nov 2018.

A flexible approach

That doctors working on slightly unusual circumstances are able to propose/submit a personalised plan relevant to their scope and have it considered by their recertification provider.

[redacted]

INCOMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:58:55 PM
Last Modified: Thursday, September 06, 2018 6:16:15 PM
Time Spent: 00:17:20
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Most specialist colleges have already programs in place that meet these requirements.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Supportive structure to help clinicians achieve these other than just dictation of perseptive political correctness.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

As long as it does not lead to duplication of processes for college requirements

Q4 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?

Generally the one porcesses are complimentary.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

The emphasis would differ for different specialities

Q6 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?

No, it is one of the more useful activities

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Keep it simple and don’t drown us in useless documentation

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:02:16 PM
Last Modified: Thursday, September 06, 2018 6:58:38 PM
Time Spent: 00:56:21
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Too complicated.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

i Feeling these changes are unnecessary and current requirements are sufficient

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes, it is time consuming and tedious and not beneficial to the clinician, I expect many would struggle with how more onirique reporting

Q4 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?

??

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Resuscitation, evidence of self care

Q6 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?

I don’t understand this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I do not think any changes should be implemented

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 7:18:48 PM
Last Modified:	Thursday, September 06, 2018 7:19:59 PM
Time Spent:	00:01:10
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Good in general

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Please consider the situation of isolated rural doctors

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Respondent skipped this question

Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 9:04:46 PM
Last Modified: Thursday, September 06, 2018 9:13:09 PM
Time Spent: 00:08:22
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Very long and wordy didn't seem much different to what I'm doing at the moment

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Don't know

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Don't know

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

I think it would be far more effective for gps to just have review, 3 yearly resus training and an annual lengthy mcq exam

Q6 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?

Peer review groups

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

I have never come across anyone who thinks pdps are any use at all

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 9:53:03 PM
Last Modified:	Thursday, September 06, 2018 10:00:51 PM
Time Spent:	00:07:48
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Concerned that by focussing employers on maintaining minimum standards, may restrict ability of specialists to continue to pursue best practice/ knowledge in new evidence.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Protected time that is rostered and paid ie included in job size

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Respondent skipped this question

Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 10:30:50 PM
Last Modified: Thursday, September 06, 2018 10:40:33 PM
Time Spent: 00:09:43
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I am concerned about the time comittment involved and the cost to a part time practitioner who doesnt work in a DHB where allocated time and money is provided for CME

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I don't see any improvement on the CPD program I already participate in.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

There already are in my CPD programme CPR Anaphylaxiis

Q6 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?

Small hospital small number of Drs to review Can hardly get the same Dr every year

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Stop reinventing the wheel Why fix a system that isn't broken You will not eliminate bad Drs just make them efficient in using the system

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 11:19:07 PM
Last Modified: Thursday, September 06, 2018 11:34:39 PM
Time Spent: 00:15:32
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Too much administration. Doctors are already dropping from burnout and suicide, adding additional administration burden to appease another administration task will only harm doctors and therefore patients.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

I suggest no change. Instead investigate how mcnz can protect doctors health better.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I see these proposals only as increased and excessive paperwork that will not add any benefit and cost tax payers and doctors money.

Q4 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?

Don't change

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Absolutely not. The colleges already cover all significant activities. Doing this in addition only increases administration and cost. It will not benefit patients, only cost the patient more.

Q6 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?

This is already done by the colleges. Please don't double up. This would be a huge waste.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Please do not increase administration. Already there is too much. Creating a recertification program is NOT evidence based, it will cost money that would be better spent improving patients access to care, it will contribute to physician burnout.

Page 2: Submission information

Q8 Your information:

Name	**Anon.**
Company	**Midcentral DHB**
Email Address	**anonymous@gmail.com**

Q9 Your position/title:

Doctor

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:44:28 AM
Last Modified: Friday, September 07, 2018 9:53:14 AM
Time Spent: 00:08:46
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I don't agree with most of it, as it is "old school thinking" that is very low on trust (despite what the document says about needing to have high trust), and ignors the mostly important driver of doctor quality and that is his/hers innate professionalism. Further you don't look to qualify the quality of the most importnat activity a doctor undertakes - the consultation. No mention is made of video reiew etc etc.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

See comments above

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

It is just box ticking of low value

Q4 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?

Plenty of concerns

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No

Q6 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?

None

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:

Name	**xxxxxxxxxxxxxx**
Company	**xxxxxxxxxxxx**
Email Address	**xxxxxxxxxxxxxx**

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 9:57:35 AM
Last Modified: Friday, September 07, 2018 10:21:51 AM
Time Spent: 00:24:15
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

The current system whereby the Australasian colleges have their own individual CPD programs works well and provides robust oversight on a medical practitioners practice. I have been randomly audited 3 times in the last 10 years.The NZMC does not need to add additional paper work designed us doing our job which actually involves seeing patients. The current ACEM CPD is comprehensive including cultural competence. I cannot for the life of me see why there are two seperate programs- either disband the the relevant college CPD or rubber stamp the CPD programs by the colleges s it wastes everyone time by doing an additional program. All these activities occupy precious time that actively practicing clinicians don't have

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Accept the current Australasian College CPD program i.e.. ACEM etc . They are entirely adequate for both patient safety and the ongoing learning requirements of the medical practitioner

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

These new activities will just take precious and very limited medical resources away from clinical work as currently most specialists are already struggling under onerous work loads. The Medical Council should be supporting doctors doing their clinical work rather than putting up barriers to seeing patient. Is there any evidence that the current system has failed and patients are being harmed? Most specialists would feel that this is just another activity proposed by 'administrative' clinicians that don't have an enormous clinical workload to fix something that is not broken but are reluctant to tell their own professional body

Q4 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?

Work with the Australasian Colleges and have a common program acceptable to both parties. If the Colleges have failed and patients put at risk then implement change otherwise continue the current system

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

No. It should be determined by the relevant College which currently have mandatory requirements .

Q6 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?

The current peer review works best

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Just talk with the Colleges regarding their CPD programs and work with them rather than against clinicians

Page 2: Submission information

Q8 Your information: **Respondent skipped this question**

Q9 Your position/title: **Respondent skipped this question**

Q10 This submission is on behalf of: **Respondent skipped this question**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 11:51:45 AM
Last Modified: Friday, September 07, 2018 11:57:53 AM
Time Spent: 00:06:07
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

360 dgree review by work colleagues, evidence of keepig up to date with current clinical practice

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

RACP CPD is adequate for keeping up to date with practice. Individuals request 360 degree from 5-6 work colleagues with breadth of disciplines.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No

Q4 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?

No

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

RACP CPD, 360 degree review

Q6 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?

360 degree review is a form of peer review. Could also have 5 yearly formal peer review from 1 specialist in a related clinical specialty

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 11:41:29 AM
Last Modified: Friday, September 07, 2018 11:44:06 AM
Time Spent: 00:02:37
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think doing an exam should not form part of this

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

None

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

No

Q4 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?

Who pays for it?

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Cpr

Q6 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?

Continuing as present attending peer review meetings

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

No

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector:	Web Link 1 (Web Link)
Started:	Friday, September 07, 2018 12:58:33 PM
Last Modified:	Friday, September 07, 2018 1:30:53 PM
Time Spent:	00:32:19
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I think the key components of the proposal are well thought through.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Placing flexibility in the program, making sure there are options for doctors to choose from since there are various conditions, especially GPs are working in; which might make some components very difficult to fulfill.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. For example, if the recertification is going to end up being onerous, older and experienced GPs might pull out of practicing medicine. The proposed approach also should include early and late feedback mechanisms from both colleges and doctors.

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Audits and ALS certification PDP guided CME activities are essential

Q6 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?

Case discussions, individual, perhaps even one to one chart reviews with peers would work the best and would be reflective of quality of the doctors' work as well.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Post implementation feedback from the Colleges and doctors would be important to assure that the changes are not counterproductive.

Page 2: Submission information

Q8 Your information:

Name	**Anonymous GP**
Company	**Anonymous**
Email Address	**anonymus**

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 3:48:27 PM
Last Modified: Friday, September 07, 2018 3:54:54 PM
Time Spent: 00:06:26
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

We are already doing this through our college and PHO structures

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

This is just structuring what we are already doing differently

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

no

Q4 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?

no

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

It differs between disciplines

Q6 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?

Group or individually based

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

no

Page 2: Submission information

Q8 Your information:	**Respondent skipped this question**
Q9 Your position/title:	**Respondent skipped this question**
Q10 This submission is on behalf of:	**Respondent skipped this question**
Q11 I wish my submission to remain anonymous	**Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Friday, September 07, 2018 7:23:59 PM
Last Modified: Friday, September 07, 2018 7:48:48 PM
Time Spent: 00:24:48
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Ther shold be no increase in time needed to do this, assess/implement as most clinicians are time poor. MSF requires co-operation of others - so if too many do this there is likely to be lack of engagement by those asked to assess. PRP is considered threatening and would need training of individuals to have competence and the Colleges will struggle. It is appropriate for CPD to be purposed and therefore an annual plan is apprpriate.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Annual performance appraisal and credentialling occurs in our DHB and probably all - just not sure what happens in private, but that is the ideal time to reflect and develop a purposed annual plan for CPD

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

I do not believe everyone doing MSFs and PRP is appropriate - logistically very hard to manage the latter and too many MSFs done by selected colleagues could have questionable validity - ? just a tick box exercise

Q4 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?

Colleges are the clinicians - they already have many roles and responsibilities and small colleges in particular will struggle to develop and monitor recertification programmes that are sufficiently generic and sufficiently specific to be appropriate for all their members

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

An annual plan of CPD activity would make clinicians more purposeful and give visibility to their employers (if they have them) so that they can be supported in their activities and for transparency in service development

Q6 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?

Recertification providers may well struggle to find volunteers to give up their precious time as most are time poor. It may be hard then to train up reviewers to give them the skills to feel competent and it may be hard to match reviewers to those with a similar practice. Financial compensation will be required and that cannot come from the Colleges but would have to come from the Medical Council if this is a medical council requirement

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

there is a gulf between idealism and prgamatism and with current staffing shortages in DHBs and chronic underfunding of services staff have a high level of burn-out. It is essential that any changes do not add to this. Any change needs to be very gradual - almost drip-fed.

Page 2: Submission information

Q8 Your information:

Name	**xxxx**
Company	**xxxxx**
Email Address	**xxxxx**

Q9 Your position/title:

Clinical Leader

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:05:16 PM
Last Modified: Thursday, September 06, 2018 6:20:33 PM
Time Spent: 00:15:16
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

they are vague

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

we already are forced to do cornerstone/foundation audits,cme,peer review,cult competence etc therec are only so many hours in the day I would look first at what the college of physicians requires of its members

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

it is just another burden to bear extra recertification requirements further detract fronm the time we have for pot care I find it most interesting that digital drs such as swift med are encouraged where there is no bricks and mortor,no patient continuity and only the fit and youg are treated

Q4 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?

let our pho set the standards they are more in touch with the publics anfd their members needsd

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

cpr training

Q6 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?

real drs in our pho would be more appropriate rather than non clinical drs from the college of gp's

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

nurture general practice or you will lose it to the virtual drs,meat market corporate practices and a&m clinics stocked with large numbers of non vocationally registered drs

Page 2: Submission information

Q8 Your information:

Name	**confidential**
Company	**confidential**
Email Address	**confidential@gmail.com**

Q9 Your position/title:

dr

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:12:52 PM
Last Modified: Thursday, September 06, 2018 6:44:02 PM
Time Spent: 00:31:09
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I see them as on a continuum we have started aleady. I'm opposed to forced practice audit . I think for GOs it must be affordable and accessible esp for small rural practices . Peer assessment for RPR is fine . I think if there are proven legal errors the more audit done.I don't welcome a punitive approach . In GP land we are assessed intensely by cornerstine . Please don't reinvent the wheel. Take into consideration part time doctors carefully - don't hound them with bureaucratic assessment . Take note of the Colleges and institutions who also monitor their doctors . I don't agree we need to study legal statutes affecting health and be expected to answer exam questions on these - generally this is not necessary as we are updated by our reading / conferences : peer advice and support etc . .should.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Use the colleges and the institutions to help lead in each speciality . We don't need to fully reinvent the system . We are so over monitored - GPs have Cornerstone , then we can be sued by ACC,-and HDC at a very high rate - one of the highest in the world !!! Also we have excellent support training and advice for medical protection societies .

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes audit will get push back . Making the RPR too heavy and formal will not be popular . It's best to encourage rather than punish / force people to do things .

Q4 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?

I can see costs soaring if you make the colleges do more assessment and audit . This will be challenging for some GPs as they are suffering from huge costs now and poor funding due to the flawed capitation system in NZ. Keep it simple and transparent . Perhaps do a trial year that people can choose to do (for more points) and then get feedback and then alter the system to make it go smoothly in future

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

It depends on your speciality !! Already CPR. Is fine GOs and others . The colleges should be able to guide you . Certainly I think you cannot practice in an area unless you have the full qualifications or supervision. I suggest the supervision system and standards needs more formality and feedback as it is currently very weak in general practice

Q6 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?

The same as what we are already having to do in GP practice / it does not need changing !! Practice audit seems onerous expensive and difficult . We are so very short of GPs in many parts of NZ - we don't want to make recruitment any harder !. In GP we have cornerstone practice review plus PHO. Practice review !! We don't need any more . You could extract the data you want from them to be honest

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Work with the college and specialty leaders .PDP is already find in GP. However many of us do not know what programmes are coming upon the year ahead and our learning needs can quickly change in response to fast moving legislation changes (typical in health in Nz) new drug rules of releases, new patient problems that pop up . So handing in of ROR. Should be handed at the end of the year not the start . It should be flexible not forced . I strongly disagree with your suggestion of essentials knowledge being forced on us - we of course should have these documents to hand and discuss them when relevant but we are not jawyers and do not need quizzing on these in a formal and tather scary manner - completely inappropriate !!! Cornerstone covers this rather well in GP.

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Thursday, September 06, 2018 6:16:46 PM
Last Modified:	Thursday, September 06, 2018 6:20:38 PM
Time Spent:	00:03:51
IP Address:	[redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

I fundamentally disagree with the need for strengthened recertification.

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

They should not be implemented. You will chase older GPs into retirement and exacerbate our doctor shortage.

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Yes. Doctors leaving the profession in droves.

Q4 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?

The RNZCGP is woefully underfunded at present. We can barely train enough GPs as it is without adding further requirements.

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Resuscitation

Q6 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?

Yes.

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Don't implement it.

Page 2: Submission information

Q8 Your information:

Name	**Dr anonymous**
Company	**GP**
Email Address	**gp.com**

Q9 Your position/title:

GP

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 5:56:19 PM
Last Modified: Thursday, September 06, 2018 6:28:42 PM
Time Spent: 00:32:22
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

if focused on daily practice and relevant then more useful as opposed to "have to do because someone else says so " approach

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Easier for group practices - as they can discuss and agree in their clinical meetings

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Regular Practice Reviews will be a challenge there are not enough "reviewers " in GP land .

Q4 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?

GP college has always been "top down" as this sometimes adds unnecessary bureaucracy to our CPD

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

no none - as GPs have very wide scopes of practice

Q6 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?

Yes RPR will be an issue of "manpower" to perform the reviews. Group general practices work well running their own peer review groups as issues relevant , foccused and cahnges can be implemented

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Issue will GPs with special interest that cross into other colleges activities - These activities should not be curtailed or disincentivised - indeed they should be more encouraged as they allow easier , cheaper , more convenient patient access to care .

Page 2: Submission information

Q8 Your information:

[redacted]

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 7:09:19 PM
Last Modified: Thursday, September 06, 2018 7:15:39 PM
Time Spent: 00:06:20
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

more pc compliance garbage, but don't worry doctors are really good at this

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

they are pointless so don't waste everyone's time with this virtue signalling nonsense

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

yes, there will not be any real buy in to this, we will just pay the money and go through the motions as usual

Q4 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?

how will pathologists doing post mortems get any client feedback?

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

yes, sending lots of money to the colleges and mcnz as is the standard practice

Q6 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?

we are already doing perfectly good peer review and don't need the mcnzs interference

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

yes, give up now, this is not going to go smoothly, too many disparate elements in the various branches of the profession to have a an overarching umbrella approach like this

Page 2: Submission information

Q8 Your information:

Name	**Ryan Perkins**
Company	**Wibble**
Email Address	[redacted]

Q9 Your position/title:

Supreme leader

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Respondent skipped this question**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Thursday, September 06, 2018 6:08:04 PM
Last Modified: Thursday, September 06, 2018 6:25:25 PM
Time Spent: 00:17:20
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

i don't see how this is different from current practice apart from semantics

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

there is lots of talk about evidence based approaches but nothing about whether there is actually evidence that any of this is important

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

time isn't free. already a significant burden of unpaid time to keep up with clinical demand. changing non clinical requirements is not going to defuse the situation.

Q4 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?

suggestions that rpr occur within the clinical enviroment will have significant effects on patient throughput in high acuity hospital areas

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

financial management, time management.

Q6 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?

groups with small numbers of specialists will find this most difficult to manage due to the effects on patient throughput

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

needs to be mandated if you want it to happen

Page 2: Submission information

Q8 Your information:

Name	**will**
Company	**not telling**
Email Address	**no spam thanks**

Q9 Your position/title:

specialist

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**

[redacted]

Collector: Web Link 1 (Web Link)
Started: Tuesday, September 11, 2018 1:13:33 AM
Last Modified: Tuesday, October 09, 2018 11:01:39 PM
Time Spent: Over a week
IP Address: [redacted]

Page 1: Feedback on the proposed strengthened recertification approach

Q1 What are your thoughts about the key components of the proposed strengthened recertification approach?

Respondent skipped this question

Q2 What suggestions do you have about how these key components could be implemented in recertification programmes?

Respondent skipped this question

Q3 Do you foresee any challenges with implementing the proposed approach? What are these and why?

Respondent skipped this question

Q4 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?

Respondent skipped this question

Q5 Do you think there are any recertification activities that should be mandatory for all doctors?

Respondent skipped this question

Q6 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?

Respondent skipped this question

Q7 Do you have any other comments or suggestions about the proposed approach that might assist with a smooth implementation?

Respondent skipped this question

Page 2: Submission information

Q8 Your information:

Name	**s**
Company	**s**
Email Address	**s**

Q9 Your position/title:

s

Q10 This submission is on behalf of: **Individual**

Q11 I wish my submission to remain anonymous **Yes**