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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,

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