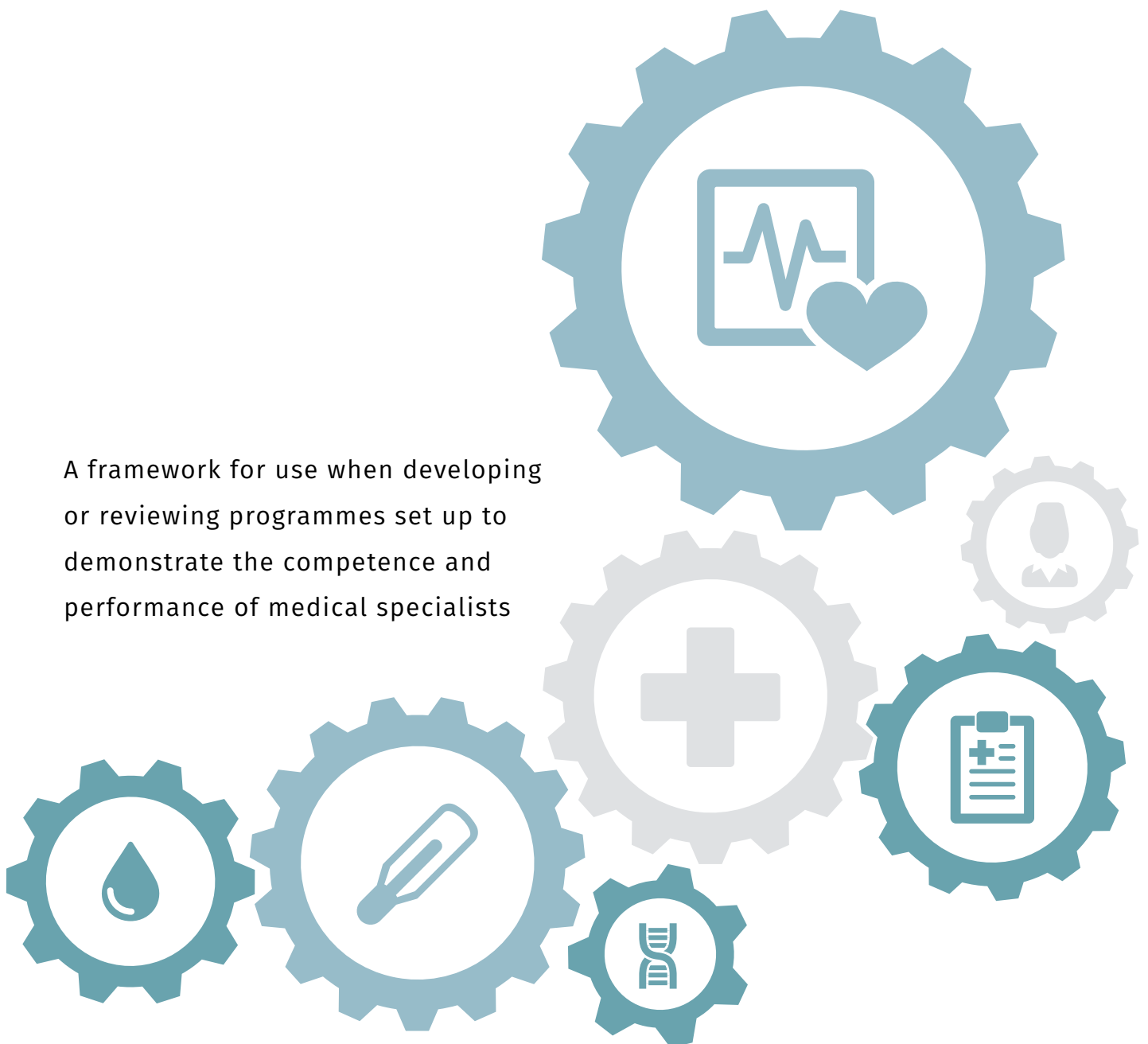


A BEST PRACTICE GUIDE FOR CONTINUOUS PRACTICE IMPROVEMENT

A framework for use when developing or reviewing programmes set up to demonstrate the competence and performance of medical specialists



A BEST PRACTICE GUIDE FOR CONTINUOUS PRACTICE IMPROVEMENT

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Medical specialists are a highly trained workforce. Stakeholders in the community have an interest in whether medical specialists are actively engaged in maintaining their current knowledge and skills as fit for purpose.

Stakeholders with this interest are:

- medical specialists themselves
- the general public, through the Medical Council of New Zealand
- the Medical Colleges and specialist professional associations
- employers of medical specialists and the facilities in which they work.

A number of processes and systems are currently used by these stakeholders to demonstrate medical specialists' on-going competence through the assessment of performance and the factors that may influence this. The purpose of these systems is to ensure that the quality of patient care is continually being improved and that medical specialists are also continuing to develop professionally.

However, many of the assessment processes overlap, and the systems operate independently. The different stakeholders desire or require different pieces of information about individual medical specialists' participation in performance improvement activities. Cycles of information gathering are frequent, and the overall reporting burden is large.

This situation has motivated the Council of Medical Colleges (CMC) and Member Colleges, the Medical Council of New Zealand (MCNZ), the Ministry of Health (MoH) and District Health Board (DHB) Chief Medical Officers to develop a framework that will enable:

- processes required by different stakeholders to not duplicate efforts of others, not lead to high compliance costs for medical specialists and not be resource intensive for Colleges and employers
- reduction in the proliferation of entirely new College programmes by allowing the Colleges to build on what others are doing
- identification and, where possible, promotion of further development of evidence-based ways to assess competence and review and provide feedback on medical specialists' performance.

The framework contains three design principles and four essential elements that should be considered when developing or reviewing processes that enable medical specialists to demonstrate their on-going professional competence.

The framework outlines three stages that all medical specialists are strongly recommended to take part in when demonstrating their competence and performance.

The accompanying stock take of resources and information used across the sector to collect evidence about a medical specialist's active participation includes tools, all of which can be used to gather evidence for the demonstration stages.

When applied in practice, the framework will enable:

- medical specialists to be able to participate in speciality-specific systems designed to ensure that their performance is satisfactory and improving, without duplication of reporting effort
- employers, when appraising medical specialists, to be able to fully utilise professional development participation measures collated by the Colleges without duplication of information
- colleges to be able to utilise relevant clinical performance measures from workplace activities to avoid duplication of information being gathered
- the MCNZ to use participation in practice improvement to inform the annual recertification process
- the public to be assured that the emphasis is on improving the quality of care and that medical specialists are continuing to develop professionally.

The stock take is provided so that any new developments in this area do not start from scratch but build upon the experience of others.

Project sponsors



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1. Introduction

This Best Practice Guide presents a framework for stakeholders and medical specialists to use when developing and reviewing systems that enable medical specialists in New Zealand to demonstrate their on-going professional competence through participation in a variety of activities likely to improve their performance. It has been developed through a project sponsored by the CMC, the MCNZ and the MoH.

Currently, a variety of approaches to measuring on-going fitness to practise have been developed. These aim to ensure that the quality of patient care is continually being improved and that medical specialists are also continuing to develop professionally. Processes and information sources that are currently used for assessment of medical specialists' performance and assumed competence are summarised in Figure 1.

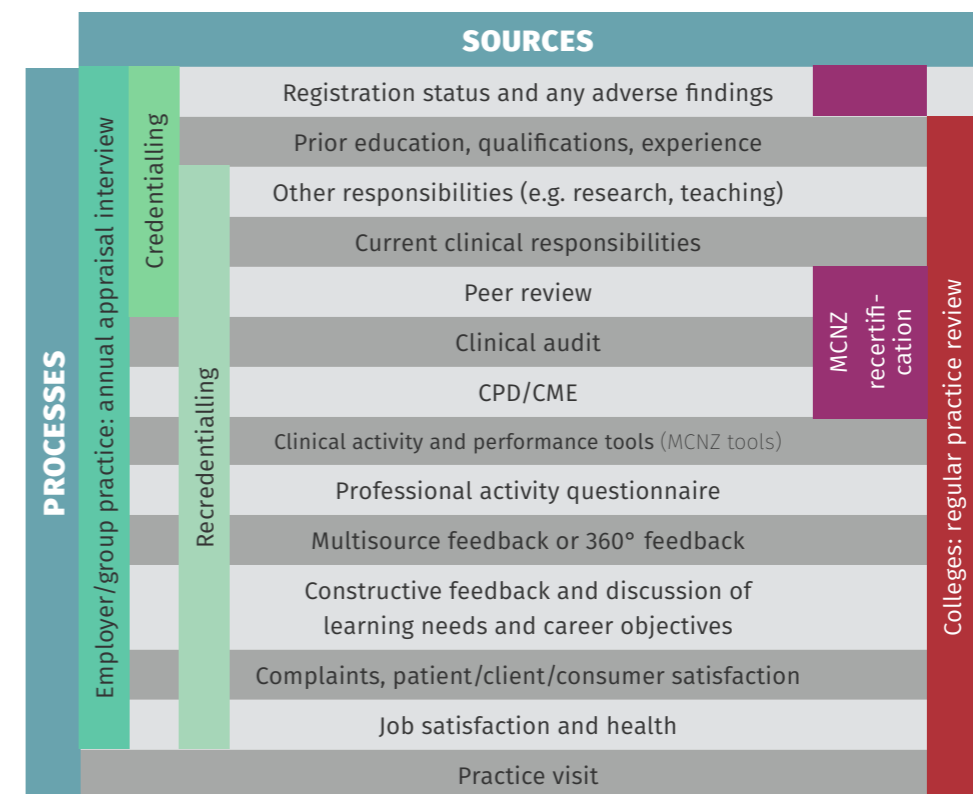


Figure 1. Sources and processes currently used for assessment of medical specialists' performance



It is clear from Figure 1 that many of the assessment processes overlap. These systems operate independently, and different stakeholders desire or require different pieces of information about individual medical specialists' participation in performance improvement activity. For the profession as a whole, the reporting burden can be large and is likely to increase.

Therefore, the operational rationale for developing a framework is to enable:

- processes required by different stakeholders to not duplicate effort, not lead to high compliance costs for medical specialists and not be resource intensive for Colleges and employers
- reduction in proliferation of entirely new College programmes by allowing them to build on what others are doing
- identification and, where possible, promotion of further development of evidence-based ways to assess competence and review and provide feedback on medical specialists' performance.

The framework, when applied in practice, will enable any new programme or review of an existing programme to build on work that has already been done in the sector. The framework promotes:

- greater emphasis on a peer or colleague 'constructive conversation' as the central building block of the participatory framework
- use of multisource feedback as an effective way to encourage self-reflection
- use of continuing medical education (CME) activities that have been shown to have a positive effect on medical specialist performance or patient outcomes
- medical specialists to release and share certain portfolio items to enable employers or Colleges to fully utilise professional development participation measures without duplication
- development of electronic web-based portfolio and electronic multisource feedback systems that integrate the needs of stakeholders in cost-effective ways.

While the definition of medical competence is straightforward, its measurement in individuals is extremely difficult. Because of its central importance, the notion of professional competence and its relationship to performance will now be considered. This will be followed by a discussion of the framework's building blocks – its design principles, essential elements and demonstration stages. The framework itself will then be presented, portfolio possibilities described, legal issues noted and the stock take introduced.

2. What is professional competence?

Professional competence of medical specialists is a complex construct. It has been defined as the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served".¹ Medical specialists need to demonstrate both clinical competence (technical skills and knowledge) and behavioural competence (interpersonal and affective skills, such as the ability to communicate effectively, use judgement and empathy and manage relationships) in their daily tasks.² The Health Practitioners Competence Assurance Act 2003 (HPCAA) also requires medical specialists in New Zealand to be culturally competent.³

Professional competence, however, is not a collection of isolated competencies. Knowledge, skills and behaviours are integrated into a whole, enabling medical specialists to use expert scientific, clinical and humanistic judgement to engage in clinical reasoning and respond accordingly. They need to be able to manage ambiguous problems, tolerate uncertainty and make decisions with limited information,⁴ often in emotionally fraught situations.

In the early 1990s, the Royal College of Physicians and Surgeons of Canada developed an innovative, competency-based framework that describes the core knowledge, skills and abilities of medical specialists. Known as the CanMEDS Physician Competency Framework,⁵ it identifies and describes a number of roles and the competencies within them. The model has been adopted around the world. For example it has influenced the development of the Royal Australasian College of Surgeons' (RACS) guide *Surgical Competence and Performance*⁶ as well as the Royal Australasian College of Physicians' (RACP) guide *Supporting Physicians' Professionalism and Performance*⁷ and the Australian and New Zealand College of Anaesthetists' (ANZCA) guide *Supporting Anaesthetists' Professionalism and Performance*.⁸

These guides support professionalism and performance and assist in the assessment of medical specialists. The discipline-specific guidance gives examples of behavioural markers: short descriptions of good and poor behaviours in each domain, which are indicators of observable and/or assessable behaviours in the working environment. These can assist the medical specialist in self-assessment of their performance and be used in an appraisal or review process.

Appendix 2.6 contains a table summarising the competency domains that are found in these frameworks. There is some variation in the choice of domains amongst the individual frameworks, and there is not a universally adopted set of domains. The table should therefore be seen as a guide to the types of competencies that are considered to be critical for specialist medical practice rather than a definitive list.

1. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287: 226-235.

2. Dubinsky I, Jennings K, Greengarten M, Brans A. 360-degree physician performance assessment. *Healthcare Quarterly* 2010; 13: 71-76.

3. HPCAA section 118 (i).

4. Epstein and Hundert, op. cit.

5. <http://www.royalcollege.ca/portal/page/portal/rc/resources/aboutcanmeds>

6. http://www.surgeons.org/media/18955288/surgical_competence_and_performance_guide__2011_.pdf

7. http://www.racp.edu.au/docs/default-source/default-document-library/sppp_guide_25052012_web.pdf?sfvrsn=0

8. <http://www.anzca.edu.au/resources/professional-documents/pdfs/Supporting%20Anaesthetists%20Professionalism%20and%20Performance%20FINAL%2020150428.pdf>



3. How does competence relate to performance?

There is an important distinction to be made between competence and performance.

Competence is what a medical specialist has been trained to do.

Performance is what a medical specialist actually does in day-to-day practice. Performance depends upon the level of competence, but it is also influenced by individual and system-related factors.

This is illustrated in Figure 2, which is adapted from Rethans et al. (2002).⁹

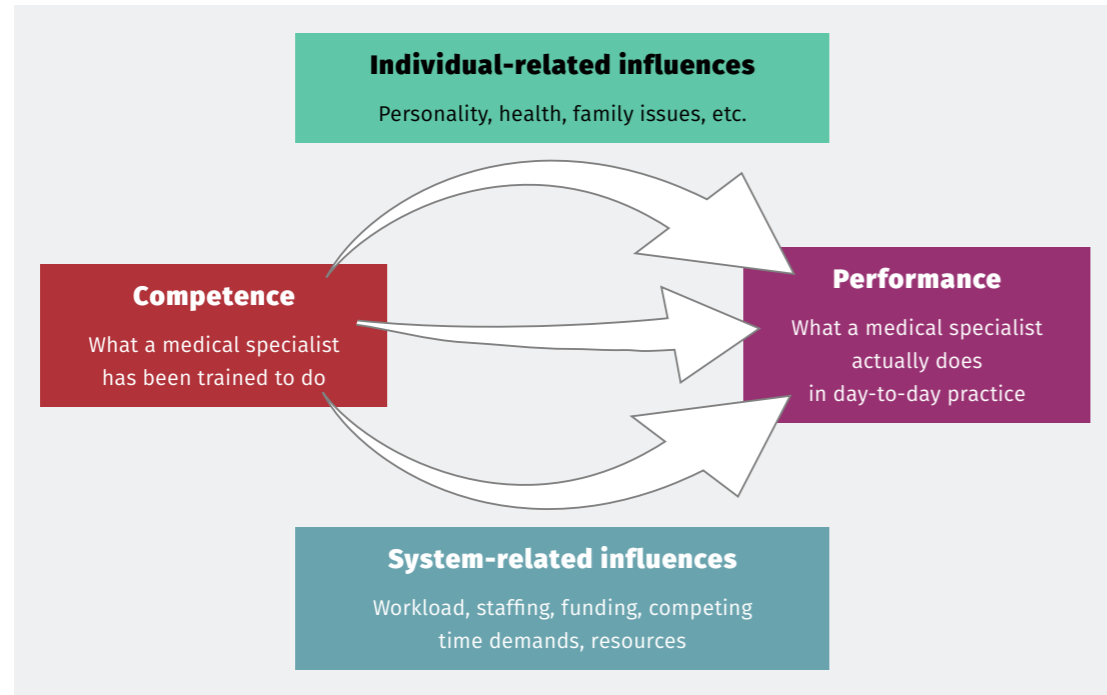


Figure 2. Relationship between competence and performance

When it comes to assessing these components, competency-based assessments tend to be measures of what medical specialists can do in controlled representations of professional practice, whereas performance-based assessments are measures of what medical specialists do in their actual professional practice.¹⁰ It is generally recognised that competency-based assessments underemphasise important domains of competence, such as integration of knowledge and skills, context of care, information management, teamwork, health systems and doctor-patient relationships.¹¹

Performance in the real world is what really matters, and this is what is increasingly being assessed in most jurisdictions. Individual and system-related issues need to be captured as part of the process of performance-based assessments in order to be able to understand their influences on performance.

9. Rethans J-J, Norcini JJ, Baron-Maldonado M, Blackmore D, Jolly BC, LaDuca T, Lew S, Page GG, Southgate LH. The relationship between competence and performance: implications for assessing practice performance. *Medical Education* 2002; 36: 901-909.

10. Ibid.

11. Epstein and Hundert, op. cit.

4. Assessing and improving performance

There is a growing body of literature about assessing and improving the performance of medical specialists that suggests the following:

- Medical specialists, like others, have limited ability to accurately self-assess. There should be more of a focus on external review of performance.
- There are still technical barriers to the objective, reliable and valid assessment of all facets of a medical specialist's competence or performance.
- Reviewing clinical performance is best done as part of a learning process through cycles of assessment, action and reassessment.
- Assessment is best if focused on the work that the medical specialist usually undertakes.¹²

When assessments of performance as well as individual-related and system-related influences are all taken together, competence can be inferred to some extent. Assessments of performance can also help clarify types and levels of intervention that may be required in order to facilitate performance improvements (for example, system-level interventions as well as individual-level interventions).

This framework was developed after extensive research of the published evidence relating to assessing medical specialists' performance and a review of the processes that are currently used in New Zealand for this purpose, as set out in Appendix 2. Therefore, for the purpose of developing the framework, the following assumptions have been made:

- Multiple performance measures are more likely than single sources to provide an accurate portrayal of performance
- An important performance measure is an individual's level of participation in a variety of activities likely to improve professional performance.
- A constructive conversation with a peer or colleague is potentially the most effective method for evaluating the evidence from professional participation in performance improvement activities and for providing feedback to enable self-reflection and enhance professional development.

All of this information points to key principles that should be taken into account when developing systems that aim to assist medical specialists to continuously improve their practice. The framework identifies three such principles, and these need to be taken into account by any College or employer setting up or operating an appraisal process, regular practice review (RPR) or other performance improvement system. They also need to be understood by any medical specialist taking part in these processes.

The framework also identifies four essential elements that should be considered when developing or reviewing processes that enable medical specialists to demonstrate their on-going professional competence.

Most importantly, the framework outlines three stages that all medical specialists should consider taking part in when demonstrating their competence and performance.

12. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance: systematic review of the effect of continuing medical education strategies. *JAMA*. 1995 Sep 6; 274(9): 700-705.



5. The framework's building blocks

The following key design principles should underpin any system that aims to assist medical specialists to continuously improve their practice.

Design principles

Principle 1: Demonstrating performance is part of a formative process

The framework places emphasis on education and continuous quality improvement rather than on judgements of performance. It is not a pass-fail or tick-box approach but an on-going improvement process. Assessments are made in order to provide guidance and feedback to medical specialists to help them identify areas for improvement and implement appropriate changes.

Principle 2: Demonstrating performance should be profession led

The framework acknowledges that standards of clinical competence and performance are to be defined by the profession, and validation should be made in the context of what is acceptable or reasonable to peers. However, it also takes into account the dual accountability of many medical specialists, who are professionally accountable to their peers or to their practice partners and managerially accountable to their employer or private service that credentials or contracts them. The ideal context is when these lines of accountability are brought together into integrated clinical service management.

For the employed medical specialist, the demonstration process may therefore take place as part of an appraisal with a medical lead with the outcome stored in the medical specialist's portfolio, or it may be part of a clinical service review process, such as that piloted by the RACP. Other options include the discussion following a credentialling (or recredentialling) process, a practice visit by peers, as with the New Zealand Orthopaedic Association (NZOA) or Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), a collegial review as happens in the RNZCGP RPR or following an external quality assurance process, for example, in specialities such as pathology or radiology.

Principle 3: Demonstrating performance is not designed to identify incompetence

If inadequate performance is identified, the response needs to include remediation and education. If the identified performance is likely to cause a risk of harm¹³ or serious harm¹⁴ to a patient, formal notification must be made to the MCNZ. In less serious cases of performance/competence concerns, advice may be sought from the MCNZ.

However, when there are small areas of a medical specialist's practice identified that need improvement, medical specialists will often be able to ensure that their continuing professional development (CPD) activities are targeted to those areas, with the assistance of a professional

13. The MCNZ states that a risk of harm may be indicated by a pattern of practice over a period of time that suggests the medical specialist's practice of medicine may not meet the required standard of competency, a single incident that demonstrates a significant departure from accepted standards of medical practice or recognised poor performance where local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern, criminal offending or professional isolation with declining standards that become apparent.

14. The MCNZ defines a risk of serious harm as one where the medical specialist may pose a continued threat to more than one patient and, as such, the harm is collectively considered serious or there is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the medical specialist poses a risk of serious harm to one or more members of the public. (<https://www.mcnz.org.nz/assets/Policies/Definitions-of-risk-of-harm-and-risk-of-serious-harm.pdf>)

development plan. Performance should then be reviewed again as part of the continuous improvement cycle.

If the areas identified are more significant, those taking part in the process of practice improvement will need to work closely with the medical specialist to ensure that CPD activities more rapidly address the deficiencies.

When reviewers have concerns that a medical specialist's practice may pose a risk of harm or serious harm to the public, those involved have a professional obligation to report this separately to the employer and the MCNZ, just as they would do if the poor performance had been identified in any other way. The MCNZ gives advice on its website for medical specialists who may have concerns about a colleague's competence.¹⁵ The MCNZ will consider the information through its usual processes and consider whether a competence review under section 36 of the HPCAA is necessary.

Essential elements

This section distils out four essential elements from the various processes that are essential to a good process by which medical specialists demonstrate their performance.¹⁶

Element 1: Demonstrating performance is a participatory process designed to encourage and increase self-reflection

Taking part in lifelong learning is now accepted as a tenet of good medical practice. Reflection is vital for learning from clinical experiences.¹⁷

For any validation of performance, medical specialists need to own and fully participate in the processes so they can learn and reflect on how they can improve their practice and identify areas where further development is needed. "With the move toward a competence-based curriculum and reflection being considered an essential aspect of lifelong self-learning, activities aimed at promoting reflection are becoming part of the curriculum at all levels of medical education."¹⁸

Reflection is not an abstract concept; it is an important tool in the practice of medicine. As previously quoted, Epstein and Hundert explain in their article on professional competence that professional competence is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individuals and communities being served".¹⁹

This is assisted by taking part in peer review. Tools used to assist assessment in this area include use of multisource feedback.²⁰ This is where peers/colleagues of the medical specialist give feedback on aspects of his or her performance and the medical specialist reflects on the feedback and compares this to his or her own self-assessment. All those using multisource feedback recognise this tool as an extremely valuable way to collect evidence that can be used to encourage and increase self-reflection.

15. Available at: <https://www.mcnz.org.nz/fitness-to-practise/competence-concerns/>

16. Where performance is what a medical specialist actually does in day-to-day practice – see section 3.

17. Driessen E, van Tartwijk J, Dornan T. The self critical doctor: helping students become more reflective. *BMJ* 2008; 336: 827-830.

18. Ménard L, Ratnapalan S. Reflection in medicine: models and applications. *Can Fam Physician* Jan 2013; 59(1): 105-107.

19. Epstein and Hundert, op. cit.

20. Also called 360° feedback.



Element 2: Demonstrating performance includes consideration of all the domains of competence

Medical specialists need to demonstrate clearly and consistently to their patients, colleagues and themselves that they are practising appropriately and in a professional manner. To do this, medical specialists need to consider more than their expertise in their medical speciality. Medical specialists need to demonstrate they are performing within their scope of practice **and** performing appropriately within a broader organisational/sector context.²¹

As noted in section 2 of this report, medical specialists need to demonstrate in their daily tasks *clinical competence* (technical skills and knowledge), *behavioural competence* (interpersonal and affective skills, using judgement and empathy and manage relationships)²² and, in New Zealand, *cultural competence*.

These have been embodied into a list of competency domains along the lines of the original CanMEDs Physician Competency Framework (as in Appendix 2.6).

Tools used to assist assessment in this area include communication tools and use of examples of behavioural markers in each domain, such as those used by RACS, RACP, ANZCA and the Royal Australasian College of Medical Administrators (RACMA). Multisource feedback is also used to obtain feedback on specific behaviours.

Element 3: Demonstrating performance includes identification of CME that can lead to an improvement in practice

Critical reviews of CME programmes show that didactic techniques and disseminating printed material alone have very little impact on performance.²³ The most effective and beneficial techniques are those that involve active interaction and engagement, including audit and feedback on optimal versus actual care, diagnosis-specific care reminders and prompts for best care, personal visits for academic detailing and involvement of opinion leaders.

The outcome of a practice improvement process should be the identification of areas for further development and the types of activities required for achieving this. These can then be incorporated into the medical specialist's professional development plan for the coming year.

Element 4: Demonstrating performance includes a constructive conversation with peers or medical seniors

Those Colleges that currently run a form of practice visit or RPR and those employers involved in appraisal processes note that the conversation the medical specialist has with a Fellow from the College, medical senior or a colleague is the element that adds most value. In practice, this process has been shown to lift performance of the medical specialist being reviewed, and it also assists the learning of those involved in the review or appraisal.

Such a conversation may thus occur at the culmination of a practice visit, as part of a performance appraisal or credentialing process, in a peer-review process, in RPR or in a practice discussion

21. Royal Australasian College of Physicians. *Supporting Physicians' Professionalism and Performance: A Guide for Physicians in Australia and New Zealand*. 2012. Sydney: RACP.

22. Dubinsky et al, op. cit.

23. See review of research collated by Dr Steven Lillis, Medical Adviser and Medical Council of New Zealand, set out in Appendix 4.

following an external quality assurance (QA) review. It is the opportunity for the medical specialist to receive constructive feedback, to reflect on his/her learning, to identify areas for development and to begin to put them together into a professional development plan.

The conversation may also give them the opportunity to explore their satisfaction in their current role, self-care and any health issues and to set performance targets for the future as well as longer-term career aspirations. Those experienced in appraisal in the employment setting advise that matters such as employment terms and conditions and departmental issues may be raised but should be put aside for discussion in a more appropriate setting. It also allows the colleague or senior to raise matters relating to performance.

Regardless of the setting, the constructive conversation covers the following:

- **The conversation is structured and takes place in a setting conducive for in-depth discussion**

The conversation should be structured in advance to ensure that key areas of performance are reviewed but should unfold as an in-depth discussion, allowing further exploration of issues as they emerge. It should focus on the medical specialist's day-to-day work and be informed by evidence from the medical specialist's practice. It should be conducive to a free and frank discussion and provide the opportunity for the medical specialist to receive constructive feedback, to reflect on their learning and to identify areas for development for their professional development plan.

It may occur annually, for example, as part of an organisational appraisal system, or every three years to coincide with College CPD cycles.

- **The conversation focuses on the positive**

Emphasising the positive aspects of a medical specialist's performance and drawing out the medical specialist's personal strengths and ability can have a substantial and positive impact on improving performance. An emphasis on weaknesses to the exclusion of other types of feedback can reduce individual performance substantially.

- **The conversation emphasises the future**

Looking to the longer term during the formal review is a positive influence. The result should be a focus on the professional development plan and identification of future learning (through CME). It may also include the setting of performance targets.

- **The conversation is informed by actual evidence**

The conversation must be based on information derived from actual practice – through activity analysis, practice visits, observation of work, audits of outcomes and reports of external quality assurance programmes.^{24, 25} The tools noted in the accompanying stock take can be applied to provide evidence to help the medical specialist, along with the peers/senior, to reflect upon current practice and identify specific targets for change.

24. IANZ accreditation is applicable to all organisations providing clinical radiological imaging. These include private radiology services and those in the public system. With accreditation, radiology services receive formal recognition of the organisation's technical competency after assessment of their processes, resources, facilities, staff and other key factors that relate to and impact on the quality of the radiological service provided.

25. Pathology laboratories undertake external quality assurance programmes as part of their quality system. Participation in external quality assurance is a requirement of all laboratory accreditation standards, such as ISO 15189:2003 *Medical Laboratories – Particular requirements for quality and competence* against which diagnostic laboratories are assessed. All public and private medical laboratories in New Zealand participate in these quality assurance programmes.



- **The conversation encourages self-reflection**

All those involved in peer review and multisource feedback recognise that evidence and feedback gained from these activities can assist with difficult conversations and enable the medical specialist to reflect on their performance as seen by others.

- **The conversation gives specific suggestions for development**

To assist with this change process, feedback needs to be supported by specific suggestions for doing the job better. Some Colleges have already developed tools to guide the constructive conversation, as set out in the stock take. If areas of weakness are identified, there must be a process for assisting the medical specialist to identify and address these through future learning using a professional development plan.

- **The conversation should be led by an experienced senior or peer**

Those who lead such conversations would benefit from participating in a training programme to ensure that they have appropriate skills, including core appraisal/review skills, skills to promote quality improvement and the professional development of medical specialists and skills to ensure that the appraisal/review is performed effectively in the setting within which the medical specialist works.²⁶ Many medical specialists already undergo training in giving effective feedback as part of their roles training registrars and/or assisting the Medical Council of New Zealand to assess interns.

- **The conversation will not be focused on matters such as terms and conditions and departmental issues**

These matters may be identified during the conversation but should be put aside for discussion at a more appropriate time and setting.

Stages of demonstration

Most importantly, any continuous improvement process should also incorporate three stages of demonstration by the medical specialist:

- **Competence** – what a medical specialist is trained to do.
- **Performance** – what a medical specialist actually does in day-to-day practice.
- **The conversation** – a constructive conversation with peers or seniors that brings all of the components together, fosters self-reflection and identifies areas for further development in the coming year.

As noted above, the starting point for a constructive conversation with a medical specialist about their performance is a portfolio of evidence demonstrating their participation in professional activities.

The conversation can be adapted to the medical specialist's situation:

- In an employment setting, the medical senior (not an external reviewer) would conduct a performance appraisal conversation with input from whole-of-department observations and from the medical specialist's colleagues.

- In private practice, this may be a review by an external peer using sufficient tools to give evidence on which to base the conversation.
- In general practice, it could include a collegial review of a medical specialist's practice, undertaken by a colleague in a 'usual practice' setting.
- In settings such as radiology or pathology, the evidence for the conversation may include feedback from an external quality audit of the practice.
- In medical administrative roles and public health medicine, the multisource feedback will be a crucial tool to gather feedback from those the medical specialist is working with, whether it be an employer, staff or a client.

Stock take

The stock take of resources accompanying this document gathers together definitions and legal requirements, tools that can be used and what they assess and additional guidance and references. An electronic version of this is available on the CMC website and the websites of project partners and sponsors and provides links to relevant documents and web resources.

The stock take resource is made available for stakeholders to organise their own assessment processes. Many of the assessment components and processes can be adapted to differing work practices in all vocational scopes. They can be used in public, private, urban and rural work settings, in the different stages of the career of a medical specialist and, with some adaptation, in relation to non-clinical and management practice.

26. NHS Revalidation Support Team. *Training Specification for Medical Appraisers in England*. April 2012. <http://www.england.nhs.uk/revalidation/wpcontent/uploads/sites/10/2014/03/rst-training-spec.pdf>



6. The framework

This Best Practice Guide provides a framework, as illustrated in Figure 3 below, that is underpinned by the three principles and four essential elements, incorporates the three stages of demonstration and uses evidence gained by using some of the tools in the stock take document.



Figure 3. A diagrammatic outline of the framework

7. Using the framework

All methods or programmes for demonstrating the competence and performance of medical specialists should consider the framework as described in section 6. The selection of performance information sources and processes (tools) will be tailored to the needs of the medical specialist's role and work setting.

Any assessment programme for medical specialists should cover three stages of demonstration:

1. A review of competence: what the medical specialist is trained to do and consideration of their professional development leading to identification of areas for future CPD and a professional development plan.
2. A review of performance: what the medical specialist actually does in practice – assessed via the use of outcomes from the audit process, peer review (which can include multisource feedback) and the voluntary use of some of the tools in the stock take document chosen with the medical specialist's specific area of practice in mind.²⁷
3. A constructive conversation based on evidence accumulated in stages 1 and 2.

When developing their assessment processes, stakeholders should note that they do not have to cover everything in one year. For example, it would be possible to cover all of the competency domains over a three-year cycle. The conversation also does not have to be exhaustive, bearing in mind that it is part of an on-going process.

Judicious use of the framework using tools from the stock take, whether organised by a College, practice or employer, will allow medical specialists to meet all stakeholder requirements and the MCNZ recertification requirements, and depending on tools chosen, it will meet the key principles of an RPR. It can also meet requirements of an individual practitioner credentialling and recertification process, an employment or group practice appraisal system and service review (as developed by RACP).²⁸ This is shown in Figure 4 on the following page.

Legal issues

There are a number of legal issues concerning the use of this information, its confidentiality and what will happen if competence, health or conduct issues are identified. These are outlined in Appendix 5.

The stock take

The stock take details resources, definitions and tools that can be used for performance assessment at this point in time. The tools available are used to build up evidence of competence and performance, and this evidence is used to inform a constructive conversation with peers or seniors. The outcome of this is identification of areas for further development, which are incorporated into the medical specialist's personal development plan. Colleges and employers or group practices or partnerships implementing a performance appraisal or review process will make a selection of the tools most applicable to their situation. In doing this, they do not need to use every type of tool on every occasion.

²⁷ For example, review of a medical specialist in sole practice may require a more in-depth look than one employed in a DHB.

²⁸ It is not intended to meet the requirements for credentialling a service, which would need a separate process.



Framework – stages of demonstration	Review of the following components	Recertification	RPR	Annual appraisal	Credentia-lling	Recredentia-lling
	Registration status and any adverse findings					
Demonstration of competence	Prior education, qualifications, experience					
	Other responsibilities (e.g. teaching, research)					
	Current clinical responsibilities					
Demonstration of performance	Peer review					
	Clinical audit					
	Training and experience and CME					
	Multisource feedback or 360° feedback					
Voluntary use of optional tools	Clinical activity and performance via tools:					
	External quality assurance processes					
	Interview					
	Case-based oral (CBO)					
	Record review (RR)			May include use of some tools		May include use of some tools
	Communication					
	General prescribing					
	Prescribing addictive drugs					
The conversation	Complementary and alternative Medicine					
	Direct observation of performance					
	Constructive feedback and discussion of learning needs and career objectives					
	Complaints, patient/client/consumer satisfaction					
	Job satisfaction and health					
	Practice visit					

Figure 4. Comparison of the framework stages of demonstration to a practice review, RPR, employer appraisal and credentialling and recredentialling

8. Future directions

Different Colleges and employers are at different stages of development, and there is no intention of introducing a single, monolithic system for all medical specialists.

Instead, the systems that are being developed or reviewed should be formulated in line with this framework, so that:

- information related to one component of performance is gathered only once and can be made available (by the medical specialist) to all stakeholders who require it
- the processes are designed with the principles and elements in mind
- when a medical specialist is taking part in a continuous practice improvement system they are able to demonstrate their competence and performance within a constructive conversation
- existing tools set out in the accompanying stock take are adapted to meet the individual requirements of different specialities so that any new developments do not start from scratch, but build upon the experience of others.

Future use of e-portfolios

Currently, most Colleges have web-based programmes to store medical specialists' CPD achievements. There is also a growing use of web-based electronic portfolios as a way of recording information that the medical specialist may collect for use in demonstrating their performance and their achievements in relation to their professional development plan. The MCNZ is now using e-portfolios for interns and general registrants, so there is a growing acceptance of these systems.

All performance information from different sources could be stored in an e-portfolio and owned by the medical specialist. This e-portfolio would provide the medical specialist with an easy way to store all the information about their activities so that they do not have to repeat any of the processes for the different stakeholders. For example, it could record the certificate of participation from their College CPD programme, evidence gained from use of any of the tools set out in the stock take document and the outcome of any appraisal or credentialling process.

The medical specialist could then release this information to any other stakeholder when they need to demonstrate their performance. All stakeholders should be able to accept relevant sections of the medical specialist's evidence portfolio so that no sources are duplicated.

During the development of the framework, it has been noted that interns currently in prevocational training,²⁹ all current general registrants³⁰ and trainee interns in the future will be required to participate in certain activities and will be collecting evidence of their participation in an e-portfolio. Consequently, an e-portfolio will be considered as business as usual. Therefore, discussions need to take place amongst the stakeholders in order to work out the practicalities of allowing a medical specialist's records to be stored in one place in an e-portfolio.

29. The assessment framework for prevocational interns provides regular, formal and documented feedback to the interns on their performance within each attachment. Each intern will have a record of learning maintained in an e-portfolio. The e-portfolio will be owned by the intern but will be accessible to the prevocational educational supervisor and the clinical supervisor.

30. The Inpractice programme delivered by bpac under contract to the MCNZ requires general registrants to take part in a regular practice review and includes being in a collegial relationship, having a professional development plan, taking part in CME, taking part in multisource feedback and meeting with the medical specialist reviewing them for feedback on their practice – a conversation.



In time, employers, Colleges and the MCNZ may wish to consider ensuring that:

- CME is focused on types of CME that have been shown to have a positive effect on medical specialist performance or patient outcomes (see Appendix 4)
- peer review includes use of multisource feedback.

As noted in the introduction to this guide, one of the purposes is to help identify and, where possible, promote further development of evidence-based ways to assess, review and provide feedback on medical specialists' performance.

This guide documents another step along the journey to demonstrate medical specialists' on-going competence through the assessment of performance and the factors that may influence this in the context of reflective practice. In this way, the quality of patient care is continually being improved, and medical specialists are continuing to develop professionally.

Appendix 1

Background to the project

The project is sponsored by the Council of Medical Colleges, the Medical Council of New Zealand and the Ministry of Health.

The Expert Advisory Group (EAG) includes medical specialists and others who represent:

- Medical Council of New Zealand (MCNZ), who protect public safety by ensuring the competence of medical practitioners
- Chief Medical Officers (CMOs) of the District Health Boards (DHB), adopted as a proxy for DHB employers who are the dominant employer of medical specialists
- Royal New Zealand College of General Practitioners (RNZCGP), who represent general practice doctors' interests
- Council of Medical Colleges (CMC), who provide a link with Member Colleges and, through them, to medical specialists
- Ministry of Health (MoH), who provide a link to other related Ministry-instituted processes, including quality standards, credentialling and clinical governance.

The group also includes a consumer representative and has involved Te ORA. The project has been informed by the experience of those currently developing and implementing appraisal systems, RPR and service reviews.

The framework set out to describe the current required elements for annual recertification of medical specialists by the MCNZ and how this meshes with the requirements of employers and Colleges and needs of consumers. Following research of current literature in the area of assessment of medical specialists, several meetings of the EAG and consultation with stakeholders, a framework was developed that can be used by those developing and reviewing programmes set up to demonstrate the competence and performance of medical specialists and by those involved in conducting the assessment process.

The stock take gathers together information and tools from these processes in order to share the information and allow new developments to be built upon existing processes. Cross-crediting of elements across the current assessment systems is also assisted by this.

During the development of the framework, it has been noted that those medical specialists currently in prevocational training, all current general registrants and trainee interns in the future will be required to participate in similar activities and will be collecting evidence of their participation in an e-portfolio. Therefore, medical specialists in the future will accept participation in processes aimed at improving their professional practice as business as usual.



Appendix 2

Descriptions of processes used by stakeholders

2.1 Credentialling

Credentialling^{31, 32} is an on-going process that commences on appointment and continues for the period of employment and is used by health and disability service providers to assign specific clinical responsibilities on the basis of their verification of:

- education and training
- qualifications
- experience
- fitness to practise within a defined context, i.e. the service provided and the facilities and support available within the organisation.

The professional focus of credentialling means that professional colleges or specialist societies have a large part to play in the process. These Colleges/societies may:

- specify the standards required for membership
- define levels of competence required for clinical practice
- nominate peers as external reviewers.

The responsibility for credentialling lies with the governing body of a particular organisation – the chief executive and the board or, in the case of a smaller private facility, the proprietor.

When credentialling the individual medical specialist, aspects that should be formally reviewed include:

- current clinical responsibilities
- clinical activity since the last review, including volumes and outcomes recommended for maintaining competence
- training and experience gained since the last review, especially as compared to what is required by Colleges or specialist societies
- future education or training possibilities and future professional aspirations
- other relevant information, such as complaints, patient satisfaction and accrued leave
- registration status, including any conditions placed on registration status or annual practising certificates
- health status
- any adverse professional or criminal record.

31. Ministry of Health. Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling. 2003. Wellington: Ministry of Health. <http://www.health.govt.nz/system/files/documents/publications/tcetoolkitconsumers.pdf>

32. Ministry of Health. The Credentialling Framework for New Zealand Health Professionals. 2010. Wellington: Ministry of Health. <https://www.health.govt.nz/system/files/documents/publications/credentialling-framework-nz-health-professionals.pdf>

Organisations should provide the opportunity for and actively encourage:

- self-review of clinical practice
- clinical audit
- peer review.

2.2 Recredentialling

Formal practitioner credentialling reviews are less frequent (interim reviews in certain circumstances aside). Therefore, the Ministry of Health recommends that a medical specialist's credentialled status be confirmed in writing as part of their appraisal review, along with a confirmation of their registration status, on an annual basis.

2.3 Recertification required by the MCNZ³³

Continual professional development (CPD) is part of the recertification requirements used to obtain a renewal of a practising certificate. The recertification programme must provide a process for maintaining and improving competence and performance (at least 50 hours per annum) and should cover the MCNZ domains of competence.

CPD programmes must include (see definitions below):

- medical audit
- peer review
- continuing medical education.

Medical audit (at least one audit per year)

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

Peer review (a minimum of 10 hours per year)

This is an evaluation of the performance of individuals or groups of medical specialists by members of the same profession or team. It may be formal or informal and can include any occasion in which medical specialists are in learning situations about their own practice with other colleagues. Peer review can also be used in the context of multidisciplinary teams, which incorporates feedback from peers or other health professionals who are members of the team. Formal peer review is an activity where peers systematically review aspects of a medical specialist's work, for example, a review of the first six cases seen or a presentation on a given topic. It would normally include guidance, feedback and a critique of the medical specialist's performance.

Continuing medical education (a minimum of 20 hours per year)

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

33. Refer to the MCNZ website - <http://www.mcnz.org.nz>



2.4 Performance appraisal

Performance appraisal monitors a medical specialist's performance against their job requirements/employment contract. Performance appraisal:

- is a formal opportunity for communication between a medical specialist and their manager
- is a process to continuously improve a medical specialist's performance and satisfaction
- gives insight into training needs and professional development
- should recognise and motivate medical specialists.

It is generally an annual process that will include:

- self-review including consideration of outcomes
- current clinical responsibilities
- feedback on the medical specialist's performance
- discussion of audit
- analysis of outcomes
- feedback from their manager and may include feedback from colleagues and the wider team (360° reviews)
- discussion of professional development and CPD
- discussion of a career plan/career objectives.

2.5 Regular practice review

The MCNZ is encouraging Colleges to develop RPR processes. The key principles of RPR include but are not limited to the following:

- RPR is a formative process. It is a supportive and collegial review of a medical specialist's practice by peers in a medical specialist's usual practice setting.
- The primary purpose of RPR is to help maintain and improve the standards of the profession. RPR is a quality improvement process. RPR may also assist in the identification of poor performance that may adversely affect patient care.
- RPR provides an assessment across the domains of competence outlined in *Good Medical Practice*³⁴ focusing on the area in which the medical specialist works.
- RPR is informed by a portfolio of information provided by the medical specialist, which may include audit outcomes and logbooks.
- Multisource feedback forms part of RPR.
- RPR must include some component of assessment by peers external to the medical specialist's usual practice setting.
- RPR must include a process for providing constructive feedback to the medical specialists being assessed.
- RPR will be led by the profession with support and assistance from the MCNZ.

34. Medical Council of New Zealand. *Good Medical Practice*, 2013. Wellington: <https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf>

- The MCNZ will encourage each Medical College/vocational and educational advisory body (VEAB) to develop an RPR process using specific tools relevant to that speciality. Alternatively, they may expand upon existing processes or tools that have already been developed by the MCNZ to include the MCNZ's principles of RPR.
- VEABs will make the process available to medical specialists on a voluntary basis (vocational scope of practice).
- The MCNZ will assess and provide feedback about the RPR process when accrediting a Medical College or VEAB CPD programme.
- The organisation or VEAB responsible for undertaking RPR must have a process for assisting the medical specialist in identifying and addressing learning needs.
- The development of a professional development plan following the RPR process should be a core component of RPR.

Tools for assessing medical specialists during RPR

RPR will be informed by a portfolio of information provided by the medical specialist. The portfolio will include details of CPD activities undertaken, audit outcomes and logbooks, if appropriate.

The MCNZ has developed a range of tools that are available to accredited providers, should they wish to use them. The tools include:

- interview with the medical specialist
- observation of consultations
- records review
- case-based oral assessment
- peer ratings
- interviews with colleagues
- knowledge testing
- analysis of data concerning prescribing and laboratory use.

The main tools and additional speciality-specific tools are in the stock take document.



2.6 Competency domains and example competencies³⁵

Medical expertise	<ul style="list-style-type: none"> Continually develops and maintains clinical knowledge, skills and attitudes. Performs an appropriate assessment of patients and provides appropriate care compassionately. Works within a scope of practice and refers appropriately.
Ethics	<ul style="list-style-type: none"> Respects the dignity and privacy of patients at all times, including confidentiality of health records. Provides careful explanations about examinations or treatments to patients and seeks informed consent before carrying them out. Maintains personal health and wellbeing. Considers the health and safety needs of colleagues, staff and team members.
Communication	<ul style="list-style-type: none"> Develops rapport and trust with patients and families. Seeks timely and accurate information during the consultation. Clearly explains to all patients the thinking behind the diagnostic process, findings and the management plan. Involves patients and families in their own care. Encourages patients to ask questions and seek information about their condition and care. Communicates effectively with team members and other colleagues. Provides effective oral and written communications about a medical encounter.
Cultural competency	<ul style="list-style-type: none"> Incorporates cultural understanding into communications. Uses interpreters and provides translated written materials as appropriate. Shows sensitivity towards different patients' backgrounds, cultural beliefs and attitudes. Provides help and support to team members from culturally and linguistically diverse backgrounds.
Collaboration	<ul style="list-style-type: none"> Participates appropriately in interprofessional healthcare. Aids a shared understanding among team members by giving and receiving knowledge and information in a timely manner.

Leadership and management	<ul style="list-style-type: none"> Prioritises workload and manages time effectively. Constructively contributes to strategic planning and management processes. Recognises the benefits of shared leadership models and fosters effective working relationships with other leaders and managers.
Health advocacy	<ul style="list-style-type: none"> Supports and promotes changes and improvements in the clinical work environment in order to improve clinical outcomes. Responds to the health needs of the community. Promotes health promotion and illness prevention at the level of individual and the community.
Quality improvement	<ul style="list-style-type: none"> Uses clinical information and patient feedback to improve practice. Compares own results with peers. Actively engages in best practice and evidence-based medicine principles.
Teaching and research	<ul style="list-style-type: none"> Contributes to the development of new knowledge through research. Facilitates education of students, patients, trainees, colleagues, other professionals and the community.

35. Based on the CanMEDS Physician Competency Framework.



Appendix 3

Standards for the activities referred to in the framework

3.1 Criteria for medical audit – set by the MCNZ for recertification

- At least one audit is required per annum.
- The topic for the audit relates to an area of the medical specialist's practice that may be improved.
- The process is feasible in that there are sufficient resources to undertake the process without unduly jeopardising other aspects of health service delivery.
- An identified or generated standard is used to measure current performance.
- An appropriate written plan is documented.
- Outcomes of the audit are documented and discussed.
- Where appropriate, an action plan is developed that will identify and maximise the benefit of the process to patient outcomes.
- The plan should outline how the actions will be implemented and a process of monitoring.
- Subsequent audit cycles are planned, where required, so that the audit is part of a process of continuous quality improvement.

3.2. Standard for peer review – as set by the MCNZ

Formal peer review is an activity where peers systematically review aspects of a medical specialist's work, for example, a review of the first six cases seen or a presentation on a given topic. Key elements include the following:

- It should include guidance, feedback and a critique of the medical specialist's performance.
- It must take place in an environment conducive to reflection and discussion.
- The confidentiality of the patients being discussed should be assured.
- The privacy of the medical specialist whose work is being reviewed should be assured.
- Mutual learning by the peers is involved.
- It should emphasise professional support and collegiality.

3. Standard for multisource feedback or 360° review

The multisource feedback process collects information from the medical specialist and their seniors, staff and peers. It is designed to evaluate a medical specialist's interpersonal, management and leadership behaviours and capabilities, not their clinical skills. The process encourages the medical specialist to assess their own strengths and compare these with assessments made by their seniors, staff and peers and to assess areas within their capabilities that may be further developed and enhanced.

- The tool should consist of a series of statements, each rated by using a six-point scale.
- The tool should be sent to a minimum of eight and not more than 10 of those who work directly with the medical specialist (such as colleagues, nurses and allied health workers) or relate to the medical specialist (such as those the medical specialist refers patients to or gets referrals from and the medical specialist's seniors and their staff).

- Those completing the tool may be selected by the medical specialist in conjunction with the person conducting the constructive conversation.
- The medical specialist should also rate themselves on the same tool.
- The tool should also give a section where those giving feedback can write qualitative statements.
- Data from the questionnaire should be reported only in aggregate form and a report given to the medical specialist prior to the constructive conversation taking place.
- Feedback must be entirely anonymous and confidential.
- The tool should be used for developmental purposes, not for assessing promotion or financial recognition.
- It should be used in the context of a high level of trust and confidentiality.
- It should be a process that is credible to the medical specialist.
- It should result in planned interventions following feedback, such as coaching in specific areas, introductions of reminders and prompts into processes.

The easiest way to conduct multisource feedback is to use electronic means so that the forms are distributed, reminders sent and results collated automatically.

Many such systems exist. For example, the RNZCGP recommends use of two tools developed for general practitioners overseas. General registrants are using a multisource feedback tool developed by the General Medical Council and implemented by bpac.

3.4 Standard for the constructive conversation

Those Colleges that currently run a form of practice visit or RPR and those employers involved in interview/performance appraisal processes note that the conversation the medical specialist has with peers (RPR), a senior (PA) or a colleague (PR) is the element that adds most value. In practice, this process has been shown to lift the performance of the medical specialist being reviewed, and it also assists the learning of those involved in the review or appraisal.

Such a conversation may thus occur:

- in a practice visit
- as part of a performance appraisal
- in a credentialling process
- in a peer-review process
- in a practice discussion
- following an external QA review.

It is the opportunity for the medical specialist to receive constructive feedback, to reflect on their learning, to identify areas for development and to begin to put them together into a professional development plan. It also may give them the opportunity to explore their



satisfaction in their current role, self care and any health issues and to set performance targets for the future as well as longer-term career aspirations.

Regardless of the setting, the constructive conversation should:

- be structured and take place in a setting conducive for in-depth discussion
- focus on the positive
- emphasise the future
- be informed by actual evidence
- encourage self-reflection
- give specific suggestions for development
- be led by a trained senior or peer
- not be focused on matters such as terms and conditions or departmental issues.

Appendix 4

Research on the effectiveness of outcomes of CME activities

Collated by Dr Steven Lillis, Medical Adviser, Medical Council of New Zealand.

Current research has been reviewed to assess what CME activities are associated with positive effect (or with no positive effect) in terms of improving medical specialist performance and/or patient outcomes.

Strongly associated with a positive effect

- Interactive programmes between practitioners and educators (3–7)
- Comparison between optimal and actual care (3)
- Academic detailing (3, 4, 8)
- Outreach programmes (3, 9)
- Providing learners with access to their own data (10)
- Teaching integrated with clinical practice (11)
- Multifaceted approach to education (4, 6, 8, 9)
- Individualised educational initiatives (12)

Moderately associated with a positive effect

- Creation of opinion leaders to influence behaviour (3, 8)
- Teaching removed from clinical practice
- Audit (8, 9)
- Providing educational material (9)
- Small-group teaching (6, 7)
- Single-discipline teaching (6)

Weak or no evidence of a positive effect

- Formal CME meetings or conferences (7–9)
- Didactic sessions (5)
- Self-assessment of educational needs
- Large-group teaching
- Cross-discipline teaching sessions
- Self-assessment (13)



References

1. Cox J, King J, Hutchinson A, McAvoy P. *Understanding Doctors' Performance*. 2006. Oxford: Radcliffe.
2. Brown CA, Belfield CR, Field SJ. Cost effectiveness of continuing professional development in health care: a critical review of the evidence. *BMJ* 2002; 324(7338): 652-5.
3. 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.
4. Cauffman JG, Forsyth RA, Clark VA, Foster JP, Martin KJ, Lapsys FX et al. Randomized controlled trials of continuing medical education: what makes them most effective? *J Contin Educ Health Prof* 2002; 22(4): 214-21.
5. Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *JAMA* 1999; 282(9): 867-74.
6. Mansouri M, Lockyer J. A meta-analysis of continuing medical education effectiveness. *J Contin Educ Health Prof* 2007; 27(1): 6-15.
7. Sohn W, Ismail AI, Tellez M. Efficacy of educational interventions targeting primary care providers' practice behaviors: an overview of published systematic reviews. *J Public Health Dent* 2004; 64(3): 164-72.
8. Davis D. Does CME work? An analysis of the effect of educational activities on physician performance or health care outcomes. *Int J Psychiatry Med* 1998; 28(1): 21-39.
9. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA* 1995; 274(9): 700-5.
10. Boonyasai RT, Windish DM, Chakraborti C, Feldman LS, Rubin HR, Bass EB. Effectiveness of teaching quality improvement to clinicians: a systematic review. *JAMA* 2007; 298(9): 1023-37.
11. Coomarasamy A, Khan KS. What is the evidence that postgraduate teaching in evidence based medicine changes anything? A systematic review. *BMJ* 2004; 329(7473): 1017.
12. Goulet F, Gagnon R, Gingras ME. Influence of remedial professional development programs for poorly performing physicians. *J Contin Educ Health Prof* 2007; 27(1): 42-8.
13. Davis DA, Mazmanian PE, Fordis M, Van Harrison R, Thorpe KE, Perrier L. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA* 2006; 296(9): 1094-102.
14. Tian J, Atkinson NL, Portnoy B, Gold RS. A systematic review of evaluation in formal continuing medical education. *J Contin Educ Health Prof* 2007; 27(1): 16-27.

Appendix 5

Legal issues

Medical specialists taking part in the continuous practice improvement processes will be concerned how the information collected is being used, who owns the information and what will happen if competence, health or conduct issues are identified.

5.1 Concerns about health or competence

Although the framework is not designed to identify incompetence, the demonstration process may raise sufficient concerns about a medical specialist's competence or health that a referral outside of the framework process is warranted.

With regard to health, the Health Practitioners Competence Assurance Act 2003 (HPCAA), under section 45, requires a health practitioner to notify the MCNZ if they have reason to believe that another health practitioner is unable to perform the functions of a health practitioner because of some mental or physical condition.

With regard to incompetence, the HPCAA does not make it mandatory for a health practitioner to report this (unlike in Australia), but it is considered a health practitioner's professional duty to report a colleague if they considers there to be a risk of harm posed by the colleague's conduct, performance or competence. The Medical Council of New Zealand gives advice on their website for health practitioners who may have concerns about a colleague's competence.³⁵

The HPCAA, under section 119, excludes anyone from liability as long as they report in good faith and with reasonable care.

5.2 The framework and protected quality assurance activities

The HPCAA has provisions that can be used to protect the confidentiality of information that arises from quality assurance activities (QAAs) involving health practitioners. The HPCAA interprets a QAA as "an activity that is undertaken to improve the practices or competence of one or more health practitioners by assessing the health services performed by those health practitioners".

Health practitioners whose work is subject to assessment as part of a QAA can apply to the Ministry of Health to have that activity protected under the HPCAA. The Minister of Health can then declare the QAA to be protected if the Minister is satisfied that to do so is in the public interest. The declaration is in the form of a notice, which remains in force for five years. This protects the confidentiality of information that becomes known solely as a result of the protected activities, including documents brought into existence solely for the purposes of such activities. It also gives immunity from civil liability to persons who engage in such activities in good faith.

35. <https://www.mcnz.org.nz/fitness-to-practise/competence-concerns/>

Some of the quality assurance activities that the framework will draw upon already have the status of a protected quality assurance activity (PQAA). This includes some QAAs undertaken within DHBs and others organised by Colleges/associations, for example, NZOA and RANZCOG are currently using the provisions of the PQAA to persuade their Fellows to take part in RPR. They believe if the RPR was not protected, medical specialists would not take part in RPR as readily.

The same types of QAAs within other DHBs and other Colleges/associations have not been placed under the protection of PQAAs. This is because many medical specialists choose to carry out the activities in an open and transparent manner and feel that PQAA status is unnecessary. There are good arguments both ways.

However, what is vital is to ensure that there is no room for doubt or confusion as to whether a particular activity is or isn't protected. Participants must know in advance whether the activity that they are about to engage in is subject to PQAA protection or not. Furthermore, for those that are undertaken under a PQAA notice, there needs to be clear understanding about the need to keep the information confidential and protected, including what can and cannot be said to others.

The protection conferred by a PQAA notice may become an issue if it comes to the point where a medical specialist's practice is considered to pose a risk of harm or risk of serious harm to the public, necessitating referral to the MCNZ. If the information demonstrating this practice of concern arises solely as a result of a protected activity, it cannot be disclosed to anyone outside of the PQAA unless the medical specialist gives consent to this disclosure or unless the information relates to conduct that may constitute a serious offence necessitating further investigation.

The NZOA issues a contract to medical practitioners undergoing RPR that notes that, if extreme deficiencies are found during the process, legal advice over further action may be sought, being cognisant of the MCNZ's requirement to report inappropriate behaviour.

On the other hand, if information demonstrating concerns about a medical specialist's practice already exists outside of the PQAA, this can be used as the basis for a referral to the MCNZ. In both situations, the MCNZ will then consider whether to undertake their own competence review or performance assessment.

Legal advice is that a College or employer should not use a PQAA protected review process if they are already concerned about a medical specialist's performance. Because of the difficulty in sharing information with (for example) the MCNZ, it would not be sensible to initiate a protected RPR in circumstances where there are already identified problems with a medical specialist's practice.

5.3 Privacy issues

The conversation and the performance appraisal process (between an employer and an employee) deal with private information of the medical specialist and as such are not normally accessible by other parties.

However, there is no law that provides a blanket protection to the disclosure of information from a performance appraisal in the way that PQAA information is protected. The question of whether such information can or should be disclosed to third parties will involve consideration of such issues as the circumstances under the Privacy Act when a person's personal information can be disclosed, the strong obligation on employers to ensure that their employees are providing safe services and the reporting provisions in the HPCAA relating to competence.

5.4 Advice to Colleges and employers when setting up appraisal, credentialling, recredentialling, RPR or continuous practice improvement processes

Colleges and employers should be specific and transparent when involved in developing any of the processes described in this document about what may happen if the processes uncover a risk of harm or serious harm or the inability to perform the functions due to a mental or physical condition.³⁶ The medical specialist should be aware before the process starts that the evidence collected as part of the process is the medical specialist's private information, and they should take responsibility for its storage (possibly in an e-portfolio).

Employers and Colleges:

- should not use a PQAA to identify suspected incompetence
- if using a PQAA process, should make the medical specialist aware that, if a risk of harm is identified, a report will be made to the MCNZ but the evidence collected under the PQAA activity will not be released
- should ensure, prior to conducting an appraisal process, that the medical specialist is aware that, if a risk of harm or serious harm is identified, it will be reported to the MCNZ
- should be explicit that, if the processes identifies a health concern that indicates an inability to perform the required functions due to a mental or physical condition, medical advice will be sought under section 46 of the HPCAA or the matter will be referred to the Health Committee of the MCNZ.

36. As set out in section 45 of the HPCAA.



Appendix 6

References

- Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance: systematic review of the effect of continuing medical education strategies. *JAMA* 1995 Sep 6; 274(9): 700-705.
- Driessen E, van Tartwijk J, Dornan T. The self critical doctor: helping students become more reflective. *BMJ* 2008; 336: 827-830.
- Dubinsky I, Jennings K, Greengarten M, Brans A. 360-degree physician performance assessment. *Healthcare Quarterly* 2010; 13: 71-76.
- Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287: 226-235.
- Medical Council of New Zealand. *Good Medical Practice*, 2013. Wellington: <https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf>
- Ménard L, Ratnapalan S. Reflection in medicine: models and applications. *Can Fam Physician* Jan 2013; 59(1): 105-107.
- NHS Revalidation Support Team. Training Specification for Medical Appraisers in England. April 2012. <http://www.england.nhs.uk/revalidation/wpcontent/uploads/sites/10/2014/03/rst-training-spec.pdf>
- Rethans J-J, Norcini JJ, Baron-Maldonado M, Blackmore D, Jolly BC, LaDuca T, Lew S, Page GG, Southgate LH. The relationship between competence and performance: implications for assessing practice performance. *Medical Education* 2002; 36: 901-909.
- Royal Australasian College of Physicians. *Supporting Physicians' Professionalism and Performance: A Guide for Physicians in Australia and New Zealand*. 2012. Sydney: RACP.
- Ministry of Health. *Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling*. 2003. Wellington: Ministry of Health. <http://www.health.govt.nz/system/files/documents/publications/tcetoolkitconsumers.pdf>
- Ministry of Health. *The Credentialling Framework for New Zealand Health Professionals*. 2010. Wellington: Ministry of Health. <https://www.health.govt.nz/system/files/documents/publications/credentialling-framework-nz-health-professionals.pdf>
- NHS Revalidation Support Team. *Training Specification for Medical Appraisers in England*. April 2012. <http://www.england.nhs.uk/revalidation/wpcontent/uploads/sites/10/2014/03/rst-training-spec.pdf>

Glossary

ANZCA	Australian and New Zealand College of Anaesthetists
CBO	case-based oral
CMC	Council of Medical Colleges in New Zealand
CME	continuing medical education
CMO	Chief Medical Officer
CPD	continuing professional development
DHB	District Health Board
EAG	Expert Advisory Group
HPCAA	Health Practitioners Competence Assurance Act 2003
JAMA	Journal of the American Medical Association
MCNZ	Medical Council of New Zealand
MoH	New Zealand Ministry of Health
NZOA	New Zealand Orthopaedic Association
PA	performance appraisal
PQAA	protected quality assurance activity
PR	practice review
QA	quality assurance
QAA	quality assurance activity
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCPA	Royal College of Pathologists of Australasia
RNZCGP	Royal New Zealand College of General Practitioners
RPR	regular practice review
RR	record review
Te ORA	Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association
VEAB	vocational and educational advisory body to the Medical Council of New Zealand

