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Te Kaunihera Rata o Aotearoa Medical Council of New Zealand

22nd July 2024

Tēnā koutou katoa

Review of the Expedited pathway for registration in the Provisional Vocational scope of practice

Consultation under section 14(2) of the Health Practitioners Competence Assurance Act 2003 on a proposed new prescribed qualification

RACS welcomes the opportunity to review the proposed expedited pathway for registration in the Provisional Vocational scope of practice.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates (IMGs) across Aotearoa New Zealand and Australia. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research.

RACS is the accredited training provider in nine surgical specialities - Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery. Surgeons in these specialties are also required by RACS and Te Kaunihera Rata o Aotearoa Medical Council of Aotearoa (MCNZ), to continue with surgical education and review of their practice throughout their surgical careers. RACS also provides advice to MCNZ regarding the current system for vocational registration for our surgical specialities and conducts IMG interviews to determine suitability to practice in Aotearoa New Zealand.

RACS is accordingly well placed to provide comment on the proposed expedited pathway.

We have used the questions provided by MCNZ to frame our response. Further, appended is a letter from the current RACS Aotearoa New Zealand Censor, who has been in the post for 10 years and has huge experience in the assessment of IMGs.

Nāku iti noa, nā

Ros Pochin FRACS
Chair Aotearoa New Zealand National Committee

Associate Professor Kerin Fielding FRACS
President

Committed to
Indigenous health

1. **Do you support the proposal for an expedited pathway, where registration may be approved without the input of the relevant college, if the applicant has a specified qualification and recency of practice?**

   We recognise the global and national workforce crisis and the need to be careful we are not imposing unnecessary barriers to IMGs whilst also exercising caution. We have concerns about how this expedited pathway for IMGs will apply to surgical specialities and note our concerns as outlined within this submission to ensure a robust and safe pathway.

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   The expedited pathway cannot be appropriately applied to all surgical specialities, for example, in neurosurgery and plastic and reconstructive surgery, the risk of an expedited pathway is too high and often the training is too variable despite superficially appearing similar. For example, Irish trained plastic and reconstructive surgeons don't have training in burns management.

   The wording needs to be more precise. We suggest:

   - "holds a primary medical degree from a university medical school approved from time to time and published on the Council's website" be changed to "holds a primary medical degree from an institution acceptable to the Council, obtained within the relevant dates, as published on the Council's website"

   - "holds an overseas postgraduate medical qualification awarded at the end of a period of specialist training and approved by Council" be changed to "holds an overseas postgraduate medical qualification awarded at the end of a period of specialist training and approved by Council, obtained within relevant dates as published on the Council's website".

   These changes would clarify the primary degree and training will continually be reassessed for suitability.

   The other criteria should state the training, qualification and experience are within the scope of practice for which the IMG is applying for registration (i.e you can't apply for vocational registration in a speciality you haven't trained, qualified and got experience in).

   If the Council can see from analysis of previous IMG applications that Colleges always or nearly always recommend IMGs as being "equivalent" according to their training - such as place of primary degree and vocational training scheme - it is logical these be recognised, and the application process be expedited. It will not be suitable for all IMGs who are applying to work in Aotearoa New Zealand.

   Concern has been expressed regarding vocational training in countries using a predominantly apprenticeship training model, although the proposed training schedule may look comparable to Aotearoa New Zealand, the experience of the individuals can be variable depending on the experience they receive though the apprenticeship pathway. It is difficult to establish with any degree of certainty the quality of such training and the expertise acquired.

2. **As part of the new qualification, there is an active clinical practice requirement – an IMG must have a minimum of 2 years' clinical experience in the past 5 years practising in that area of medicine, in a country recognised by Council as having a health system comparable to Aotearoa New Zealand, prior to application. In your view, is this set at the right level?**

   For most areas of clinical practice this may be appropriate. For scopes of practice that include a motor skill aspect (including surgical specialities, obstetrics and gynaecology, ophthalmology), this should be considered further and only 2 years practice in the last 5 years is NOT consistent or robust enough to warrant an expedited pathway. For an expedited pathway in surgery this experience should also be specifically defined as being at consultant level.
   We suggest the criterion for recency of practice should be changed to:

- "an IMG must typically have worked for a minimum of 2 years FTE equivalent clinically as a consultant in the last 4 years AND at least 6 months FTE should be in the last 18 months".

This would allow for time off for children/other leave whilst also ensuring recent clinical experience. RACS Neurosurgical Fellows involved in IMG assessment consider the time period should be longer than two years, ideally 5 years at consultant level with discretion that permanent posts would be viewed more favourably than 5 x 1 year locums at different locations. For some vocational specialities it may be that the IMG is still suitable for an expedited pathway, but MCNZ should recommend a suitable return to work programme if the IMG hasn't practiced in the last two years.

3. Do you see any potential adverse consequences, and if so, how can they be mitigated?

It is possible certain vocational areas (for example Anaesthetics) may be "flooded" with IMGs and these doctors find employment in preference to doctors trained in Aotearoa New Zealand. This could be mitigated by using the expedited pathway only for those doctors who already have a job offer, will work in "at need" areas of medicine, or are looking for a job in a hard to staff area (such as rural).

Consideration must be given to the current pipeline – for example, currently, Aotearoa New Zealand trains approximately 15 general surgeons each year but half of these stay overseas after their fellowships as they are unable to gain employment here or consultant posts in Australia are perceived as being more attractive (the starting salary for a year 1 consultant is more than our highest consultant wage). Considering ways to attract these homegrown surgeons back to Aotearoa New Zealand must be a higher priority than fast-tracking IMGs.

Attention must be paid to the cultural safety of the doctors and their ability to integrate into the Aotearoa New Zealand Healthcare system. This can be mitigated by ensuring that Te Whatu Ora mandates that all new IMGs undertake an appropriate orientation before taking up any post in Aotearoa New Zealand that includes a Te Tiriti o Waitangi workshop, unconscious bias training, ACC and HDC information. We acknowledge most hospitals already do this, but it is not guaranteed or sometimes provided in a timely manner. Appropriate support and mentoring must also be provided to IMGs as they adapt to working here and integrating their families.

Consideration must be given to reviewing the guidelines on a regular basis or having time periods attached to the vocational training schemes that are deemed appropriate. Training schemes will change over time and may become more or less suitable – this must be monitored to ensure the expedited pathway continues to be appropriate. This should be mitigated by ensuring the training programme is time bound for appropriateness (i.e suitable from 1986-2000 or from 2003 forward) and there is regular consultation to check the end times for this training programme are appropriate to be extended or can be added to the expediated pathway if they are felt to have been made more suitable

The burden of assessing appropriateness for practice in the speciality in Aotearoa New Zealand is moved to the employer/department to ensure due diligence and adequate supervision during a proposed shortened supervisory period. MCNZ should develop a better structure and evaluation of the supervision process in conjunction with the professional colleges. The decision about a suitability of an IMG to be awarded vocational registration should be performed by a panel who assess not only the supervision reports but also 360 degree evaluations of the IMG or where appropriate in the non-expediated setting a vocational practice assessment. It needs to be clear that the supervisor is not the decision maker on a IMG's suitability to proceed.

MCNZ should also develop guidelines for exiting IMGs who are not suitable for the environment/situation/hospital in which they have been placed.

4. Do you have any other comments regarding the proposal?

We would like to see a fuller explanation of the three stages of the MCNZ process for Specialist IMGs.

- Ensuring the IMG's experience and training is equivalent (under either the expedited process or the usual process where the specialist college provides a report on the individual candidate's characteristics and suitability to do the job)

- Providing supervision and support to ensure the individual IMG is confirmed suitable for and able to integrate into the hospital and community in Aotearoa New Zealand.

- Identifying those IMGs who are not suitable and enabling them to be exited from the Aotearoa New Zealand Healthcare system.

Greater focus is needed on the processes for stages 2 and 3 above to ensure the success of the expedited pathway. The burden of supervision primarily falls on the hospital department and, in the context of significant health workforce needs, this could result in inadequate supervision, or a desire to retain the SIMG simply to relieve the workload of the other departmental members despite emerging issues. Additionally, there is currently no external validation of the supervision process.

The UK anomaly of non-numbered (non-trainee registrars) fulfilling training requirements but not formally trained in a speciality would need to be addressed specifically for Surgery and excluded as time counted towards training experience.

There is a risk of selection bias, where the high level of equivalency observed in certain disciplines from specific countries may reflect the calibre of the applicants rather than the quality of their training. Introducing an expedited pathway from these countries could lead to lower-quality candidates applying simply because it is easier to obtain provisional vocational scope.

Tighter definitions of what constitutes "equivalent" and "as satisfactory as" would be useful.

5. The current proposal is initially aimed at IMGs who have completed postgraduate medical training in the UK or Ireland. We have also identified four areas of medicine initially suitable for the expedited pathway, as well as three areas of medicine that require further exploration.

a) Are there any additional areas of medicine that should be considered for IMGs who have completed postgraduate medical training in the UK or Ireland?

b) Are there any postgraduate qualifications from other countries that should be considered?

c) If so, what are the relevant postgraduate qualifications?

This pathway may be suitable for fully trained Orthopaedic Surgeons who have been trained in UK or Ireland, have CCT from UK and have appropriate active practice; typically they must have worked for a minimum of 2 years FTE equivalent clinically as a consultant in the last 4 years AND at least 6 months FTE in the last 18 months). From RACS's experience assessing IMGs, there is not another group of Orthopaedic Surgeons who could go through an expedited process.

In general, UK and Irish Surgeons across all RACS specialities have lower primary operator rates than Aotearoa New Zealand Surgical Education and Training Trainees. More UK graduates are completing training with a sub-speciality focus and are able to elect to sit an exit examination with a subspecialty focus rather than the very generalist fellowship examination that is applied in Aotearoa New Zealand. Limited scopes of practice would need to be considered for these surgeons. This is relevant because in most Aotearoa New Zealand hospitals all surgeons are expected to have a broad scope of practice, especially to have the ability to do acute and emergency call.

Employing hospitals need to assess logbooks to ensure that surgeons practice within their experience; hospitals do not currently review logbooks. If this requirement was not part of the expedited pathway, it might well be that surgeons were practising in areas where they haven't gained competence or haven't practised recently. Hospital credentialing processes need to be robust enough to monitor this aspect.

6. Do you have any other comments regarding the proposal?

The proposal is sound as long as strong criteria are applied and reviewed regularly, and the supervision process is strengthened.

MCNZ would be well advised to continue to work closely with RACS and other colleges as this is introduced.

The initial step is primarily about determining whether an IMG's training and experience are sufficient for them to practice safely in Aotearoa New Zealand. Helping an IMG integrate into Aotearoa New Zealand and providing support and supervision are crucial for their success in the Aotearoa New Zealand context. Additionally, having a defined exit pathway for those unsuitable for practice here is essential.

APPENDIX

Winscribe Number	1969846
Dictating Author/Clinician	Nigel Willis
Date of Clinic/Dictation	12/07/2024
Letter to:	Submission to NZ Medical Council

The public of Aotearoa New Zealand rightfully expect the standard of surgical care they perceive to be of the highest standard.

This concept is strongly supported by the Medical Council of Aotearoa New Zealand.

The Royal Australasian College of Surgeons undertakes training across nine specialties within the surgical domain. The standard of that training and education is of the highest standard and indeed could be the highest standard achieved internationally.

When assessing specialist international medical graduates, the Royal Australasian College of Surgeons is required to assess the training of those individuals and compare it to the RACS standard. In doing so, not only is it necessary to evaluate the technical expertise and experience of the applicant, but also compare for comparability across the 10 surgical competencies that are embraced by the surgical education and training programme.

The RACS programme has a robust process of continuous assessment of the trainee's performance which is documented and reviewed by the surgical education and training committees of the various specialties. This is one, but obviously not the only way, to assess an individual's performance and to highlight any areas of concern. Many of the international surgical training jurisdictions do not have this measure in place or if they do have a process, it is not as comprehensive nor necessarily does it assess across the broad range of competencies required to complete surgical education and training as that as understood to be in the RACS environment.

As a paper-based exercise, some aspects of this are easier than others. It is relatively straight forward to assess the exposure of an individual to surgical procedures, both in terms of complexity and volume. It is much harder to assess however, whether or not that individual has performed those procedures independently without oversight or whether there has been a significant contribution from more senior members of their faculty.

Assessing for non-technical skills is much more complicated.

The aim of this exercise is to ensure that the people who are working in Aotearoa New Zealand surgery meet a standard that will allow them to practice safely, efficiently and to be able to work in a manner which is both collegial and culturally sensitive.

In spite of this process which is done with great diligence, assessments are not always accurate and occasionally the assessment over-evaluates the capabilities of the IMG. These situations have, and I am very aware of this although will not elaborate here, placed the Aotearoa New Zealand public at great risk.

I understand it is the intention of the Medical Council of Aotearoa New Zealand to have an expedited pathway in order to increase the flow of people entering into the IMG programme in a manner that avoids unnecessary delay.

From my 10 years' experience as a Aotearoa New Zealand censor for the Royal Australasian College of Surgeons, I believe there is only one jurisdiction internationally that has sufficient comparability to the RACS programme to be considered for an expedited pathway. That is the training programme of the United Kingdom. I should note, however, that I am also aware that the standard of training in terms of

technical expertise and general experience for those graduates from the colleges of the United Kingdom, is not quite at the standard of those from the RACS programme.

It is much less clear that the standard achieved by people from mainland Europe, South Africa, the United States and Canada has been met. The reason for this is that the volumes are often much smaller, the complexity of the cases undertaken is less and in many cases the duration of training is significantly abbreviated compared to the RACS model. The breadth and scope of training is often very different as well and would not prepare an individual for work in the public hospital environment where it is necessary to have a broad skill set to enable participation in the on-call roster and to be able to deliver the requirements of departmental activity.

I am also aware that the burden of supervision is considerable and that somehow this is expected to be automatically factored into departmental activities. Not all departments have the capacity or even the skill set to undertake this supervision in a manner which is robust and reproducible. It is an unremunerated activity, both for the individual undertaking the supervision activities, as well as for the department which is required to adopt this burden. An expedited pathway would require, I imagine, a much more intensive supervision protocol to be adopted and I doubt that many departments, in the current workforce and demand environment, have the capacity to perform this activity reliably.

Thus, it would not be my recommendation to have a widespread expedited pathway, nor would I recommend that the RACS supports such a model.

I believe it would be useful to compare the accreditation process and surgery to that which occurs in other professions. I am very aware that in engineering, teaching and the law, that there is a very high standard required to be met by overseas individuals in order to have their international qualifications recognised. All of these measures are in place to protect the Aotearoa New Zealand public and ensure the highest standard of delivery of professional skills at every level.

Whilst it is not within the purvey of this document, I think it is worth highlighting that one of the reasons that specialist international medical graduates are required is because we have failed for many years to train enough people locally to undertake these tasks. We have used the resources of other nations to train and then taken that expertise and relocated it to our own benefit. This process or methodology has conspired to permit health workforce planners in Aotearoa New Zealand to not be pressured to assess the local issue and make appropriate adjustments to medical school intakes and the funding and support for advanced training programmes. This is true not just of surgery but of all parts of medicine and is no doubt one, but obviously not the only, reason why we have a workforce crisis here in Aotearoa New Zealand.

In summary, and in agreement with my colleagues who have also commented on this matter, the only jurisdiction which should provide an expedited pathway would be for those IMGs from the United Kingdom, the jurisdiction which has the closest model of training compared to the Royal Australasian College of Surgeons. No other jurisdiction should be included in this pathway.

This letter has been sighted and
electronically verified by the undersigned.

Nigel Willis, FRACS
Orthopaedic Surgeon