28 February 2007

Mr Philip Pigou
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Dear Mr Pigou

Pilot Performance Evaluation Programme

Thank you for the opportunity to comment on the Medical Council of New Zealand's consultation paper, *Pilot Performance Evaluation Programme* (the Paper). I commend the Council for taking this initiative, but I do have concerns about the pilot.

Rationale for introduction of the programme
The rationale implied is that the current method of identifying poorly performing doctors through concerns raised about their practice is not sufficient because "evidence from Canada shows that doctors who have concerns raised about their practice are no more likely to be found with deficiencies in their practice than [sic] when matched with doctors who have no such concerns raised" (see 2.1).

Actually the JAMA article reference shows no such thing. The study compared doctors who had been referred by a registration body as a result of a disciplinary hearing or peer review with two other groups. The referred doctors were much more likely than the randomly chosen doctors in the "control" group to be judged deficient after the whole assessment (and on all individual tests), eg "cannot practice without supervision" and "moderate to severe difficulties", 11/37 in the referred group versus 0/26 in the control group.

Clearly the current method of identifying poorly performing doctors through concerns about their practice does work, even if it identifies only a minority of substandard doctors. (It seems appropriate that doctors in this category should be targeted whatever the Human Rights Commission might say.)

Nevertheless other methods are needed as well.

Rationale for the pilot
This is poorly expressed but seems to be to evaluate the validity of the pilot performance evaluation programme (PEP) and, in particular, the use of the colleague/patient/self questionnaire (CPSQ) as a screening test to identify doctors who have competence problems on a number of dimensions (see 2.1).

To do this, the PEP needs to be evaluated against a “gold standard”. In this case, to find out how well it identifies doctors who are already known to be performing poorly.

In an attempt to do this, the pilot has compared two groups: one group who have not met recertification requirements and volunteers from a second group who have (with a low response rate, not given but can be derived, of about 30%).

There are two problems with the choice of groups.

First, they go against the logic of the document. In the document it is stated (2.1) that the MOPS programmes are “learning systems which do not, and are not designed to, identify poor performance”. If that is so, doctors who fail to meet their MOPS requirements are not known to be performing poorly and hence are not the appropriate “gold standard”.

Secondly, the low response rate in the “control” group suggests that it is unrepresentative of all doctors.

Interpretation of results

The flaws in the study mean that the results do not show what they purport to: that poorly performing doctors can be recognised by other doctors but not by patients or other non-medical colleagues. It is very disappointing that premature publicity about the flawed results has led to the invalid conclusions in the media that “Patients fail in doctor diagnosis” (*Dominion Post*, 7 February 2007, A7).

The results could be interpreted as showing that doctors who have failed to meet their MOPS requirements are regarded by their fellow doctors as worse in a number of areas than a subset of doctors who are highly compliant.

The fact that reports from patients and other health professionals did not show major differences between these groups could of course mean that doctors who fail MOPS are not actually worse at communication etc than doctors who pass – as the document indeed suggests!

In order to determine whether the PEP is worth having, and what dimensions are worth having, a different sort of study needs to be done.

What sort of pilot should be done?

Validity testing has probably already been done in Canada using the (CPSQ) if it is being used widely there. So other aspects are what need to be piloted here.

If it is really a screening tool then it should be able to divide doctors into those who possibly have a problem with competence from those who don’t, and would be followed by a diagnostic test to determine whether the screen positive doctors really are incompetent. Action would then be taken.

Piloting a screening programme that has already been shown to be valid might entail examining feasibility, ie the update, the number of doctors who had the complete number of patient questionnaires, and the acceptability. Some of these things are

reported and the acceptability seems okay. But the next step of doing further investigation of those below a cut off does not seem to have been done at all.

General comments

In my view a system of regular assessment of doctors' practice is essential if the Council is to fulfil its statutory mandate of ensuring the competence and fitness to practise of doctors in New Zealand. The system should be valued by the medical profession, trusted by the public, effective, and sustainable in the long term.

The CPSQ provides valuable feedback on a doctor's practice and is a potentially important source of information for patients in finding a "good doctor". It is essential that patients can be confident that they are attended only by good doctors who give optimal care.

The term "good doctor" was discussed in Liam Donaldson's groundbreaking report in July 2005, *Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*.[1] Although there is no universally accepted and operationalised standard to define a "good doctor",[2] the report recommended that standards of practice consistent with the definition of a "good doctor" should be agreed upon, and embedded into medical registration and licensure, certification, education, and contracts of employment. It also proposed that doctors should have their competence to practise assured through revalidation, relicensure, and recertification.

In my view, in New Zealand, the Council should take a leading role in setting the standards for "good doctors". The professional Colleges or BABs have a complementary role for those doctors registered within a vocational scope of practice. However, the Council must carry the ultimate responsibility and be accountable as the regulatory authority under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act). The principal purpose of the Council under this Act is to protect the health and safety of the public by ensuring doctors are competent and fit to practise medicine. Competence and fitness to practise can only be secured for all members of the public through regular recertification.

Traditionally, it has been accepted that all doctors are implicitly good unless the regulatory authority or other agencies can show that they are "bad". The tendency of regulation has been towards a risk-based approach where some doctors' practice are looked at more closely than others. The appropriateness of this for doctors is questionable as there is no clear way to determine which doctors pose a risk. Furthermore, the strategy is not compatible with the concept of a ensuring a good doctor for all members of the public.[3]

It is important to ensure that medical regulation is not limited to the identification of poor practice. The regulatory system must be able to demonstrate that all practising doctors reach and maintain specified professional standards throughout their careers.

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[1] Donaldson, L., *Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*, Department of Health, London, 2006.

[2] Ibid., p. xi.

[3] See Irvine, D., "Editorial: Good doctors: safer patients – the Chief Medical Officer's prescription for regulating doctors", in *Journal of the Royal Society of Medicine*, vol. 99, September 2006, p. 1, 2.

There must be a systematic way in which doctors can assess the quality of their practice and identify opportunities to improve it. The concept of CPSQ is a step towards this – 360° feedback has a role in supporting, quality assuring, and improving the practice of all doctors, including the vast majority who (it is assumed) already perform at an acceptable standard, as well as identifying competence concerns.

The complaints about doctors received by my Office involve not only the adequacy and appropriateness of clinical practice, but also issues related to professional and ethical behaviour, communication with patients, and appropriate relations with patients. The CPSQ is a positive move from the traditional peer review for recertification purposes. Feedback from co-workers and patients, as well as from medical colleagues, is a valuable source of information, particularly on attributes such as patient interaction and information for patients.

I appreciate that the Council's recertification requirements include demonstrating participation in continuing professional development (CPD) — peer review, clinical audit, and continuing medical education, or a College or BAB recertification programme (MOPS)). Thus, recertification requirements typically focus on clinical knowledge and technical competence of doctors rather than less technical matters such as interpersonal aspects of care, information for patients, office staff, patient interaction, patient satisfaction, and physical office. These were attributes on which feedback was sought from patients and co-workers for PEP. Valuable information can potentially be obtained from the CPSQ. Indeed, members of the public and doctors believe that assessment through recertification should cover a wide range of professional skills, attitudes and behaviours, not merely technical competence.[4]

In a similar vein, I note the research commissioned from the MORI Social Research Institute for the Department of Health to examine the attitudes of the general public and doctors towards medical regulation and assessment in the United Kingdom. The findings from the public surveyed emphasised that while patients want their doctors to have good clinical knowledge and technical skills, they also rate the interpersonal aspects of care as equally, if not more, important.[5] This accords with other research that has been conducted into public attitudes and patient experience. A British study suggested that the routine practice of doctors can be influenced by feedback from patients, and other studies have reported the feasibility and value of physician performance appraisal by patients, peers, and hospital nurses.[6] Multisource feedback, using questionnaire data from patients, medical colleagues, and co-workers, as adopted by the College of Physicians and Surgeons of Alberta, is gaining acceptance and credibility as a means of providing doctors with quality improvement data as part of an overall strategy of maintaining competence and certification. Multisource feedback systems can be used to assess key competencies such as communication skills, interpersonal skills, collegiality, medical expertise, and ability to continually learn and improve, which medical organisations and the public believe need attention.[7]

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[4] Donaldson, L., op. cit., p. 159.
[5] Ibid., p. 146.
[6] See Hall, W. and others, "Assessment of physician performance in Alberta: the Physician Achievement Review", in *Canadian Medical Association Journal*, 1999, vol. 161, p. 52, 53.
[7] Violata C. and others, "Multisource feedback: a method of assessing surgical practice" in *BMJ*, 2003, vol. 326, p. 546, 548.

Thus, the CPSQ is a valuable step in highlighting areas for improvement. In reviewing a doctor's practice, there is a need to ensure that the practice is safe, opportunities are taken to improve practice, and professional development and training needs are identified and met. The CPSQ has a role in ascertaining why a doctor has been unsuccessful in recertification, with follow-up through a tailored plan of remediation and rehabilitation to address any deficiencies.

I note that the flowchart on page 5 of the Paper does not indicate time frames for following up concerns, other than the quarterly reports on progress for the group of doctors who are of a high level concern. There does not appear to be any monitoring by the Council of those doctors with low level concerns, where the Council has recommended that the doctor develop a CPD programme focusing on areas of concern. I trust that the Council will ensure a formal follow-up process for such programmes.

While the Council has opted to audit 10% of practising doctors each year, I am supportive of a more comprehensive approach that involves as many doctors as possible. A voluntary process may be one way to achieve this. The standards review process for independent midwives was initially a voluntary process, which used a self reflection review tool, in addition to performance data based on the standards required for best midwifery practice. It included peer and consumer review. It enabled shortcomings in midwives' practice to be identified and appropriate action to be taken. I understand that compliance was high and the approach was supported by members of that profession. However, the process has now become mandatory under the HPCA Act and applies to all midwives holding a practising certificate.

Set out below are some comments to the specific questions that have been raised in the Paper.

Question 1 – The CPSQ as a tool in the performance assessment toolkit

Yes, I consider that the CPSQ as a tool in the performance assessment toolkit is a valuable use of the CPSQ and very important. I understand that peer ratings are currently used in performance assessment. However, feedback from a wider range of relevant persons, including co-workers and patients, would provide valuable information, as discussed above. The usefulness of the tool would also depend on the terms of reference identified for the assessment of a doctor's performance. Barriers include being more resource intensive in terms of time and personnel to carry out assessments, as well as the ability to select a sufficient number of people who are in a position to provide comprehensive, relevant feedback.

Question 2 – The CPSQ as a tool in the assessment of IMGs applying for registration within a vocational scope of practice

Yes, this would be a valuable use of the CPSQ. I understand that the Council is moving towards competence-based assessment for those international medical graduates applying for registration within a vocational scope of practice. That is, a move from the traditional BAB examination to other forms of assessment for those applicants holding an overseas qualification which the Council considers is "equivalent to, or as satisfactory as, a prescribed qualification" pursuant to section

15(2) of the HPCA Act. Therefore, the CPSQ would be a very useful part of the toolkit in this assessment.

The CPSQ would allow for wider feedback than from medical colleagues on such matters as patient interaction, and its use is consistent with the Council's move towards competence-based assessment. The CPSQ would have to be used in conjunction with other tools, such as record review and direct observation.

There are a number of barriers. The CPSQ requires the applicant to have been in a stable working environment for any feedback to be useful; there would be difficulties in the provision of accurate feedback from co-workers and patients from any short term placement (for example, less than one year at one centre). There may also be difficulties in finding sufficient people to provide comprehensive feedback; the process is resource intensive, particularly if it is to be used for all IMGs applying for a vocational scope; and the interpretation of the results gives rise to further questions – for example, if an IMG is rated poorly by patients, do they have to upskill in this area or does it mean they are unable to gain registration within a vocational scope of practice in New Zealand?

Question 3 – The CPSQ as a tool used by BABs
Question 4 – The CPSQ as part of DHBs' credentialing process
Question 5 – The CPSQ as a practice quality assurance and improvement tool for PHOs

Yes, there is potential value in the CPSQ being used by other bodies such as BABs, DHBs and PHOs. However, in my view the Council should be taking a leading role in this process. It is for the Council to ensure that doctors are competent to practise medicine in order to protect the health and safety of members of the public. For the CPSQ to provide useful information, there is a need for it to be used with consistency and reliability. I refer to my comments above about the sort of pilot that is needed. The process and interpretation of results should be carefully monitored by one body. For all of the suggested future uses of the CPSQ, the tool requires evaluation so that there is a better understanding of its usefulness and opportunities to refine the tool where indicated.

It is important that any process which assesses doctors' performance does not become unnecessarily bureaucratic for little return. I am well aware that additional resources are required to carry out the CPSQ. To ensure consistency and avoid duplication of work between agencies, collaboration between agencies is appropriate for any use of the CPSQ. I support the Council taking a lead role. If BABs are to use the CPSQ tool for recertification purposes, the Council needs to ensure that the BAB recertification programmes meet the appropriate standard and that the tool is being applied consistently.

Furthermore, I note that annual declaration of CPD is required from all doctors with their application for an annual practising certificate; however, the Council does not generally require documentary evidence of participation in a BAB recertification programme with every application, and will only follow up on compliance with the BAB in some cases. The BABs have some responsibility for specialist recertification, but this is non-mandatory for those doctors in general practice. While the Council's role is recertification, the BABs have a complementary role. The BABs'

recertification programmes assist doctors to demonstrate the maintenance of their professional standards and maintain their registration within a vocational scope of practice by meeting part of the recertification requirements of the Council. However, as the Council has the overall responsibility both for the overall quality assurance of the recertification process and recertification decisions in individual cases, assessments such as the CPSQ should be led by the Council, not the BABs.

Question 6 – Medical colleague feedback as part of CPSQ
Question 7 – Co-worker feedback as part of CPSQ
Question 8 – Patient feedback as part of CPSQ

As discussed above, I fully support the concept of feedback on doctors' practice not only from medical colleagues, but also from co-workers and patients. I note the survey carried out by the College of Physicians and Surgeons of Ontario about physician and public perception about what should be required of physicians. It showed that 84 percent of the general public considered that doctors must receive formal feedback from patients about communications.[8] There are gains for the Council, in terms of its role in protecting the health and safety of members of the public, to be seen to be patient-orientated, and in being able to demonstrate to the public with conviction that it can be trusted and respected. This will, in turn, benefit the public.

I trust the above comments will consider future use, and further evaluation, of CPSQ.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

cc: Professor John Campbell
Dr Alistair MacDonald
Dr Ross Boswell

[8] Donald Irvine, *Everyone is Entitled to a Good Doctor*, 30th William Osler Lecture, McGill University, Canada, November 2006.