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Dear Joan

Thank you for the opportunity to comment on the Medical Council of New Zealand's consultation document, *Consultation on a new framework for supervision of international medical graduates*. I commend the Council for proposing a new framework for supervision which aims to provide improved benefits to the health sector.

Role of Health and Disability Commissioner

As Health and Disability Commissioner, I am charged with the role of promoting and protecting the rights of health and disability consumers as set out in the Code of Health and Disability Services Consumers' Rights (the Code). Under section 14(1)(d) of the Health and Disability Commissioner Act 1994, one of my functions is to make public statements in relation to any matter affecting the rights of health and disability services consumers.

Many of the matters addressed in the consultation document fall outside my jurisdiction as Commissioner. However, patients certainly have an interest in knowing that, when they need medical services, they will be able to access doctors "in the right place, at the right time, and with the right skills". The comments that follow are fairly general and follow the questions posed.

General comments

I appreciate the drivers identified by Council for a new model. I also recognise that workforce shortages have resulted in New Zealand being highly reliant on IMGs to provide health services. Patient safety is clearly paramount, but flexibility is also important. The challenge for medical regulators is to develop a pragmatic solution for the supervision of IMGs, which strikes a sensible balance between protecting patient safety without creating unnecessary administrative hurdles.

1. What should formal supervision involve?

I note the Council's definition of supervision and the features of formal and informal supervision set out at page 2. It would be helpful to focus on the nature of supervision rather than its structure. In this regard, it is important to make a clear distinction between

the nature of supervision and a collegial relationship. The provision of guidance and feedback in the context of a doctor's experience are common elements of both supervision and collegial relationship.

I also find the terms formal and informal supervision unhelpful in the context of Council's supervision requirements. Supervision is supervision.

In my view, supervision should include inter alia:

- induction and orientation to the specific clinical environment eg, hospital ward
- regular protected time
- face-to-face meetings (which is critical during the initial stage)
- direct observation of an IMG's communication/interaction with patients, family, peers, and other team members
- review of cases including patient assessment, patient management, and record-keeping
- direct observation of technical procedures
- an IMG's attendance at continuing professional development activities such as CME
- ensuring appropriate professional behaviour and appreciation of the cultural context
- documentation of progress eg, signing off competencies, recording attendance at CME.

Closer supervision should always be provided when a supervisor has concerns about an IMG's practice.

2. *It has been suggested that offsite supervision would not be appropriate under any circumstances. Do you agree with this statement? If not, under what circumstances would an offsite supervision arrangement be appropriate?*

Given the constraints that the New Zealand health sector currently faces, offsite supervision should not be discounted as an option. However, offsite supervision should only be provided in exceptional circumstances. Clearly, there are situations where IMGs should not be placed in a position where onsite supervision is unavailable eg, an IMG new to the country placed in isolated rural practice.

The critical issue that precludes wider acceptance of offsite supervision is isolation. Isolation is the "kiss of death" for a doctor (and department and DHB) and must be avoided. An offsite supervision arrangement may be appropriate where an IMG is working in a structured environment and support is readily available. For example, an IMG working in urban general practice, where there are strong local support networks or hospital care close by. Offsite supervision should occur only within a supportive framework that includes audit, peer review, CME and practice visits where appropriate.

3. What sort of arrangements, contractual or otherwise, would organisations need to enter into to implement the proposed framework for supervision?

There are a multiplicity of organisations and individuals involved in supervision arrangements. Therefore, it is difficult to comment on this question.

However, I suggest that Council give serious consideration to involving the relevant branch advisory body when making arrangements for IMGs intending to work as medical officers.

4. *How do you see this supervision framework working for a regional model of service delivery? What specific supervision requirements would be appropriate for a regional model of service delivery?*

Supervision often involves multiple supervisors in different locations. Although there are a number of possible service delivery models, I consider that the model of service delivery has little impact on how supervision is carried out. The specific supervision requirements should always be assessed on a case by case basis regardless of the model of service delivery.

5. *How should this arrangement be funded?*

Funding arrangements fall outside my jurisdiction as Commissioner. Therefore, I am unable to comment on this question.

6. *What are the workforce implications for the proposed framework for supervision? How could these challenges be met?*

It appears that the Council is attempting to formalise a complex framework with significant resource requirements. It is my view that many regional and provincial centres will not be adequately resourced to support the proposed framework. It will only work if Council is flexible and allows employers and supervisors to develop supervisory arrangements that meet the spirit of the proposed framework within resource constraints.

Employers must be able to support supervisors – provide cover to allow for protected time and training of supervisors. Employers also need to support IMGs in the supervision process. Therefore, it is vital that employers understand Council's requirements and purpose of supervision.

Some of the requirements of the proposed framework – particularly a minimum period of one month assessment and credentialling of all IMGs – seem impractical and would place unnecessary burden on the workforce (discussed below).

7. *a) Is it appropriate to implement one flexible framework which can be applied for a wide range of situations? How could this work?*
   b) Alternatively, should a number of frameworks be developed for different situations? ie, for supervision of IMGs registered within the different pathways for a:
   - provisional general scope of practice
   - provisional vocational scope of practice
   - special purpose scope of practice?

It is appropriate to implement one flexible framework. The development of a number of frameworks should result in unnecessary complexity and limited buy-in. Council's requirements must be easily understood and applicable in practice. If Council is flexible in its application of a framework, then it should meet the needs of any situation.

8. *How should a supervisor, working in a large hospital or primary care practice, assess the suitability of an IMG to work in a provincial or rural hospital or small practice after only a short period of time working directly together? What steps should be taken to help the supervisor make this decision? What should their time working directly together involve?*

The requirements of supervision (discussed above) provide a framework for the supervisor to make a judgment on an IMG's suitability to work in a provincial or rural hospital or small practice. The supervisor as a senior clinician is best placed to make this assessment. If appropriate, the supervisor may assess the IMG by a practice assessment at the provincial/rural hospital or small practice.

9. *Offsite supervision might mean that the larger hospital will have to take some responsibility for the IMG and allow them to spend time working in their hospital. What are the issues with this and how is this best facilitated?*

Employers need to support Council's framework if it is to work in practice. In most cases, an IMG will be working within the same DHB so there is a pre-existing employer-employee relationship. If this is not the case, the IMG's employer and host facility will have to come to an agreement on arrangements.

10. *Can offsite supervision work over a lengthy period (some IMGs are under supervision for 24 months)? What can be done to ensure that it works appropriately over an extended length of time?*

It is difficult to comment on this question in the absence of any objective information about the effectiveness of long term offsite supervision. However, to ensure offsite supervision is effective, it is important that supervision requirements (discussed above) are met, supervisory relationships maintained, and timely supervision reports are provided to Council.

11. *Is this framework appropriate? If not, what changes would you recommend?*

The proposed framework is a good starting point, but appears to be overly complex given the current constraints within the health sector. Therefore, it is unlikely to be workable. As discussed above, sufficient flexibility should be allowed given the nature of the situation.

It would generally be sufficient to have a supervisor working in the same vocational scope of practice at the same work site regardless of how many vocational registrants are onsite (point 2a on page 4). The quality of supervision and the supervisor's judgement is more important than the number of doctors working on site. Both the supervisor and IMG have a responsibility to participate and engage in the supervisory process (for example, see Case 05HDC07953 which considers the responsibility of both parties). It is also unclear from the document whether it is Council's intent that the onsite vocational registrants are working in the same or related vocational scope of practice as the IMG.

Point 4 on page 4 sets out the requirement of working with the primary supervisor for a minimum period of one month as part of an initial assessment. In my view one month for all IMGs is unsustainable. A two week period would be appropriate in most circumstances; one or four weeks may be contemplated where special circumstances arise.

I have concerns about the value of tying up a valuable resource such as a senior medical officer for one month when in the majority of cases two weeks of initial assessment is likely to be adequate. The inherent risk in a one month assessment period is that once the supervisor is satisfied of an IMG's competence, he or she is likely to leave the IMG mostly to their own devices for the remainder of the supervision period.

I also consider it impractical to credential all IMGs. The focus of credentialling should be on senior medical officers who practise independently. I am not convinced that it is necessary to credential trainees (except medical officers who are in effect acting as specialists). In the DHB setting, trainees will always be working under the supervision (regulatory and/or clinical) or oversight of a senior medical officer.

It is unclear whether one or two supervisors provide supervision and support for ongoing clinical work at point 6 on page 5.

The flowchart (page 9) appears to presuppose that all supervision is offsite. To avoid confusion, I suggest you either change "clinical duties commence at home site" to "ongoing clinical duties" or moving "clinical duties commence" above initial assessment.

12. *Council is undertaking a number of initiatives and developing resources that may support supervisors. These include induction and orientation guidelines, training for supervisors and this proposed framework. Are there any other ways Council could support supervisors?*

It is important for Council to advocate on behalf of supervisors to ensure adequate support is provided by their employers. The supervisor's role has to have substance and real meaning to the employer, profession and IMGs and recognised. Council must take the lead in ensuring supervisors have adequate tools and support.

It is also important that Council works collaboratively with other stakeholders to ensure its work is integrated towards common understandings. For example, work by the Medical Training Board, and the Ministry of Health's credentialling project.

I am concerned that my comment about delegating care has been taken slightly out of context ("Liability for Supervisors" at page 7). To clarify, in the Whanganui Inquiry (Case 07HDC03504) I stated: "A basic principle of *clinical supervision* is that the supervisor may delegate care to the supervisee where he or she has good reason to believe that they are competent to carry out the delegated tasks" (emphasis added). In the inquiry report, I made a distinction between regulatory supervision and clinical supervision, and also referred to Professor John Campbell's article published in the *New Zealand Doctor*, "Supervision – why the concern?" (September 2007).

Other comments

Supervision of IMGs needs to be robust and proper to ensure public health and safety. Supervision and supervisors must be real. If shortcomings are indentified during supervision, the supervisor must address these. If this is not feasible, the supervisor must alert the Medical Council and their employer.

I trust these comments are helpful. I wish the Council well in this important work.

Yours sincerely

Ron Paterson
Health and Disability Commissioner