International Medical Graduates

It is a characteristic of all complex organisations that new people who join need effective orientation and induction processes, tailored to fit the organisation's culture and the needs of the individual. This is true also for international medical graduates (IMGs). IMGs provide a valuable resource within our health system; however, they need to be supported to assist them to perform well in a New Zealand context. Matters such as communication and manner may be heavily influenced by cultural experiences and expectations (Katie Elkin "Registration decision-making and public protection: international medical graduates in Australia and New Zealand" 2015 Canadian Public Policy). These issues may be compounded by inadequate assessment, orientation and supervision, a lack of social and professional support, and differences in training experiences.

It is the Medical Council's role to ensure that doctors registered in New Zealand are competent and fit to practise. This includes responsibility for registering new IMGs and reviewing reports from its regulatory supervisors during the IMG's provisional registration period. However, the Council's responsibility does not detract from a DHB's obligation to have robust recruitment practices and adequate supervision in place. If a DHB or other employer has or should have reason to believe a doctor may pose a risk of harm to patients it has a duty to respond immediately to minimise the risks. In 2008, HDC investigated issues with the surgical competence of a doctor who had trained in the Czech Republic. It was found that his qualifications and background were not properly checked before he was granted medical registration and that he was not appropriately supervised following his appointment. It was noted that his supervisor was stretched in his ability to perform all his tasks, particularly his administrative responsibilities, and was working in an environment of constant time pressures.

It was found that the doctor's referees should have been independently checked and his last employer and/or supervisor should have been contacted. Furthermore, the DHB failed to facilitate the supervision process by ensuring that enough time and resources were set aside for adequate supervision to occur.

A similar situation arose in a recent HDC decision (15HDC01280). In 2011 an overseas trained orthopaedic surgeon from the United States (Dr A) applied for a position with a DHB. The DHB's recruitment policy required at least two references, at least one of which needed to be from a previous manager, preferably the applicant's current or most recent manager. The DHB's credentialing check list also required a written reference from a colleague who had worked with the applicant within the previous 12 months. Dr A provided three written references from orthopaedic surgeons with whom he had worked, but in each case he had done so more than two years previously. The references alluded to communication difficulties and noted concerns regarding Dr A's demeanour and personality. However, Dr A was appointed to the role without more current references being required.

Another orthopaedic surgeon acted as Dr A's supervisor. The DHB had no guidelines or policies in relation to supervision requirements and relied on clinicians adhering to the Medical Council of New Zealand's supervision guidelines (Medical Council of New Zealand "Orientation, Induction and Supervision for International Medical Graduates" January 2011). The supervising surgeon said he was not given enough time for supervision and, in order to do the job properly, he would have needed to lessen his clinical time.

Three written complaints were received regarding Dr A's manner of communication, personality, and demeanour. However, the supervising surgeon was not made aware of the complaints and when a new business manager took over in 2014, she was not advised of any concerns. The complaints database at the time did not name clinicians, and so the emerging pattern of concerns was not evident. A fourth patient complained about Dr A's communication issues and failure to

recommend appropriate surgery. By that time, Dr A was no longer under supervision. Later in the same month a fifth complaint was made regarding a patient requiring revision surgery.

By early 2015 the new business manager recognised that Dr A was receiving more complaints than his colleagues and raised this with senior management. Finally, in 2015 one of Dr A's colleagues sent a formal letter of complaint to management stating that he would resign if his concerns regarding Dr A were not dealt with. An external review of Dr A's practice was commenced and an extension to his contract was cancelled. The external review report found that the Head of Surgery and Chief Medical Advisor (amongst others) were aware that before moving to New Zealand Dr A had received complaints.

The Commissioner found that in addition to the registration role of the Medical Council of New Zealand, the DHB had an obligation to take reasonable steps to ensure that its clinical staff were fit for the position to which they were appointed. That included an obligation to select competent staff and monitor their continued competence; provide proper orientation and supervision of staff; and establish systems necessary for the safe operation of its hospitals. The Commissioner was critical that the DHB demonstrated a lack of care in the way in which Dr A was employed, particularly for failing to secure a recent reference and failing to have in place adequate systems to identify an emerging pattern of concerns. The Commissioner was also critical of aspects of the DHB's supervision and monitoring process, and its processes regarding induction and orientation. The Commissioner made a number of recommendations in relation to improving the DHB's recruitment, supervision, performance management, and complaints management processes.

However, responsibility does not rest solely on employers. The NZMA Code of Ethics (2014) provides that doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Performance issues should be raised internally initially but, if that fails, relevant bodies (such as MCNZ) should be informed.

Despite the issues raised in this case it is important to acknowledge the valuable contributions in terms of experience and cultural diversity that IMGs make to New Zealand health care. In order for IMGs to perform at the highest level they should be provided with adequate assessment, orientation, supervision, and professional support.

Dr Cordelia Thomas, Associate Commissioner
Health and Disability Commissioner
NZ Doctor, 12 December 2018