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Response to Medical Council of New Zealand

**Consultation on a new framework for supervision of international
medical graduates**

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Medical Council of New Zealand - Consultation on a new framework for supervision of international medical graduates

1. What should formal supervision involve?

Supervision should provide access to support for medical practitioners as well as being a method to have oversight of practise for practitioners who are new to the New Zealand health system

Types of support:

- Collegial - ensuring doctor has access to and is involved in peer review activity, CPD opportunities
- Oversight – assessing safety and competence of practitioner.
- Clinical - point of reference for queries i.e. to discuss difficult/unusual clinical cases.
- Advisory - provide advice, recommendations for management issues, cultural issues
- Personal - to be a confidential sounding board for concerns of either a clinical or practical nature.

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?

We do not agree with this statement.

NZLocums recruitment service is unique in that we are funded by government to provide both short term locum cover to rural GPs and longer term and permanent recruitment services. With regard to short term cover, our aim is to provide 2 weeks cover per year for in excess of 400 rural GPs. By the very nature of this work we are regularly making arrangements for 'roving locums' to move around the country, changing practices on a regular basis and typically staying in one location from 2-8 weeks.

In order to make these placements we operate with a pool of locums, typically recruited from overseas (IMGs).

We take into account the locum's level of experience and training when scheduling their work here and are particularly careful to take into account the level of support available at a receiving practice.

We are regularly faced with situations where a rural GP in a small practice (less than 3 GPs) requires time off and in order to find cover for them we need to consider our pool of available locums. Whilst we avoid placing a newly arrived IMG into such a situation, once they have completed their first few weeks placements in larger, well supported group practices, we do need to be able to make arrangements for off-site supervision on a regular basis to assist the many smaller rural practices who are in desperate need of relief for their GPs.

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

The proposed framework for supervision does not generally fit with our model of hiring general practitioners (IMGs) to work in a locum capacity.

As described in response to question #2, our MoH contract specifications have a requirement that we provide a high volume of short term locum relief cover to rural general practitioners. We are concerned that our ability to comply with the requirements of the contract may be compromised due to the affects of the new framework for supervision of international medical graduates.

However in order to address the proposal to have both on-site and off-site supervision available to IMGs (specifically within the comparable pathway to provisional general registration) working in New Zealand, we are currently considering and scoping a proposal to have a pool of NZ qualified, vocationally registered GPs available to provide the recommended off-site supervision.

In order to enable an initial relationship to be formed between the supervisor and locum we are currently investigating ways to facilitate this. It could for instance be an option for the named supervisor to attend our Orientation course (organised for all newly arrived

locum GPs working through NZLocums) in order to meet with the locum prior to them going to their first placement.

Following this initial meeting, the supervisor would be available for ongoing support and be available to the locum during the length of time they are working in New Zealand.

Alongside this arrangement we would also propose to make the usual provision for on-site supervision on a case by case basis at the various practices to which the locum is sent.

The immediacy of *clinical* supervision for IMGs doing short term locums needs to be matched with their scope of practice. The expectations of a 2 week locum is to be able to maintain the status quo for the absent practitioner and deal with urgent cases up to the locums level of comfort and skills and to effectively refer those beyond that skill level. This is different from the expectations of longer term locums staying in a practice for several months where additional responsibilities of ongoing responsive and anticipatory care are required.

Cultural and interpersonal supervision is also important for the short term remote locum to ensure safe patient and professional interactions. These issues are frequently picked up by non-medical practice staff who would be an important resource for an off-site supervisor and the framework needs to acknowledge the potential roles of nurses, receptionists, practice managers and patient advocates

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?

In order to deliver the remote supervision as described in 3) above we are currently investigating the possibility of setting up remote peer review/supervision support groups. Methods for delivery are being investigated for video conferencing facilities to enable groups of GPs to meet regularly and allow opportunity for more remotely situated practitioners to be well supported.

There will of course be challenges to work through in order to implement such a model such as the availability/funding of broadband access/video conferencing facilities to

enable the support to be delivered. However we would be interested to receive feedback on the feasibility of such a model and once we have an agreement in principle we would further scope the project.

5. How should this arrangement be funded?

This is one of the key challenges with the implementation of the framework. Who pays for the time involved? (Time for the Supervisor's services, time for the practitioner to work alongside an off-site supervisor.)

Also, what funding is available to provide remote supervision services such as video-conferencing etc?

From the perspective of NZ Locums, the cost of supervision could be included in the 'package' of expenses required to see an IMG safely placed in the remote practices. This extra cost would then have to appear in the price for the overall service contracted with the MoH. As the MoH is ultimately responsible for maintaining an effective workforce, this would seem appropriate, however this would need to be discussed further with the Ministry.

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

The impact of these changes upon the locum service which we provide is potentially far reaching and the level of support that we are able to provide to rural general practices is likely to be significantly affected. It is often the smaller and more remote practices, for whom cover tends to be harder to provide, who are more affected by the implications of these changes.

Decisions will need to be made around whether or not we are able to fulfil the requirements for the supervision arrangements in order to make placements. This could leave some practices in situations without a GP at all if the locum cover cannot be put in place. Our service is set up and funded through government to address retention issues for rural GPs. We have a duty of care to provide the required locum relief to take a rest and refresh – this is essential for retention. (See comment on funding in #5 above.)

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, and**
- **special purpose scope of practice?**

Flexibility in approach to individual supervision requirements for rural general practice is paramount.

Practice situations vary however, there are many practices that either do not have a vocationally registered GP on site or have less than 3 practitioners on site.

Out of 202 rural general practices we note that there are 70 sole practitioners, 32 practices who have no vocationally registered practitioners on site and a further 60 practices who only have one vocationally registered practitioner working within their team.

Clearly it is these practices with sole practitioners or smaller teams who are more often requesting to use our service as larger practices with more than 2-3 practitioners are more likely to cross cover for breaks.

We have many examples of practice situations where their request for locum cover has been particularly challenging due to the necessary supervision arrangements.

- Catlins Medical Centre in Owaka has a long standing request with us to provide a long term/ permanent doctor for their practice. The sole GP currently working there has also requested her 2 week locum cover on an annual basis. This has been particularly challenging to deliver due to the remote nature of the practice and lack of collegial support available on-site if the sole GP is away taking a break.
- Another example is Raukawa Iwi Services in Shannon. They do not currently have a GP working at the practice and rely upon locum cover to provide a service to their community. As we identify locums to work there we have a constant

challenge to make acceptable arrangements to support the locums. A recently arranged locum placement will involve a GP from a practice in Levin agreeing to spend one morning per week away from his own patients, to work alongside the locum for his first two weeks. The supervisor will provide GP services to a neighbouring community at the expense of his own practice and patients. This is the solution we found to maintain the critical primary health care service for the community of Shannon, however it is not ideal and not something we regularly wish to see.

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?

We have included a letter from Otago Southern Region PHO (see Appendix One) which outlines the concerns at Balclutha Hospital in respect of the new framework for providing supervision and the challenges presented to them in terms of finding adequate supervision cover to enable them to resource their facility.

For short term locums of whom a somewhat less sophisticated scope of practice is expected (see #3 above) the main requirement is that they can be observed in their fundamental decision making processes, their documentation and their interpersonal behaviour with patients and staff. As mentioned above (#3) liaising with other practice staff will contribute to the initial assessment of the locum's safety of practice. It is always going to be impractical to supervise the locum across the full range of possible presentations. The short time together, assessed over the course of a few days should be sufficient to get an early impression of the locum's overall safety after which open channels of communication regularly visited can provide the continuation of the supervisory process covering the aspects identified in #1.

For this process to be effective the supervisor will need training and dedicated time for the job. It is not a role to be tacked onto the side of a full-time clinical commitment. There are already too many other demands competing for such space.

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?

Considering the above question in relation to rural primary health care:

In situations where there are no vocationally registered GPs at a practice, off site supervision has generally involved an MCNZ requirement for the locum to spend time working alongside the supervisor (typically in the supervisor's practice) for a defined period of time (MCNZ have usually quoted a period of 2 weeks) prior to commencing at the place of employment either on their own or working alongside non vocationally registered colleagues.

Whilst we understand the requirement, this period of working alongside the offsite supervisor to develop the supervision relationship has often been very difficult to arrange due to various factors:

- Lack of a vocationally registered GP in the area
- Reluctance from an available vocationally registered GP to provide the service. This has been for various reasons ranging from personal disputes/local politics to reluctance to 'be responsible' for the locum and reluctance to accept a perceived risk.
- Tension between the practices involved over who will pick up the cost of the locum's salary during this period.
- The supervising GP not having a spare consulting room in their practice to accommodate the locum.
- Time constraints to orientate to practice for 'roving locums' moving around from place to place to cover many short term placements for rural GPs

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?

We believe offsite supervision can work over an extended period of time for some situations.

We have discussed the possibility of having a pool of dedicated named supervisors who provide a second level of independent support for roving locums during their entire period in New Zealand. (see response to Q3 for more detail)

The initial period of personal contact between supervisor and IMG is fundamental to ongoing off-site supervision. Where this supervision continues over an extended period of time it would be reasonable to expect that, periodically, further opportunities for face to face contact are found. This might be at a maximum of 6-monthly intervals. In between, opportunities for video-conferenced meetings could be used. Video-conferencing would only be used as a substitute for the 6-monthly face to face meetings as a last resort. (*The times proposed are notional and debatable.*)

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

As proposed, the framework does not fit for our delivery model of providing GP locum services to rural general practice.

We feel that consideration needs to be given to develop supervision requirements appropriate for locum GPs (i.e. IMGs who are qualified to specialist level in their home country, have the relevant work experience and are intending to remain in New Zealand for less than 2 years to undertake a period of locum work, either in one location or as a 'roving locum' moving from practice to practice).

Our current work around establishing a pool of vocationally registered, NZ based GPs to provide 'off-site supervision' allied to the work around exploring the use of video conferencing technology etc can be considered within this respect.

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?

Training and guidance for supervisors is important. Also encouragement in this area of professional responsibility could assist. All too often we are faced with situations where vocationally registered GPs decline to provide the supervision or sign up to the Medical Council's agreements then through various circumstances fail to deliver the service or not treat it with the level of responsibility it commands.

The Council needs to formally recognise and advocate for financial reward for the time and responsibility involved in supervision which are magnified in the context of rural off-site supervision. A modest pool of expert rural supervisors would require each to spend a significant part of their working week, perhaps up to 4/10 working in this role.

The expectations of supervisors also needs to be realistic. Only the most elaborate and expensive supervisory arrangements could be expected to cover all eventualities which would be hugely wasteful if the primary assessment of Curriculae Vitae and the checking of references have been properly done. Even then unexpected adverse events would still happen. The detection of frankly incompetent or ill-prepared clinicians should be possible with modest levels of on-site supervision from enthusiastic, well trained and resourced supervisors.

OTHER COMMENTS

We do not feel that the intention to have 'Initial assessment' and 'Credentialing' as outlined in 'The Proposed Framework' fits with our current model of short term locum placements.

APPENDIX ONE



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Our local rural hospital in Balclutha has been recruiting medical officers from overseas, for a number of years. During this time we have been utilising one of our senior local GPs, who also works as part time medical officer, as supervisor. Recently we have been advised that there has been changes to the medical council's regulations around supervision, which means our current set up is no longer acceptable.

At the time that we received this information we were in the process of finalising details for a new recruit from USA. The sudden change to the supervisor regulations proved quite a difficulty for us, as our new medical officer is due to arrive in Mid January 2009 and to find a supervisor for her at Dunedin hospital was extremely difficult, particularly at a time of year when so many staff are on annual leave.

Not only is there difficulty in finding someone to supervise our new staff, but added cost in commuting or accommodation costs in Dunedin for our staff while they complete their training. Other concerns include the very different environment that a big city hospital offers a new Doctor, compared to the facilities they will be coming to in their role with our rural hospital.

If this change in requirements is to be permanent we wonder if there is a need for some new processes around this area of recruitment. Suggestions we have include:

- 1) An in house training programme for overseas doctors be developed, similar to the police force where they bring in an intake of new staff from overseas and they are all based in Wellington for a set amount of time to complete orientation, training and NZ studies before being sent to their new posts around the country.
- 2) District Health Boards employ a supervisor/ support Dr in a roving role that would travel around the DHB area checking in on and supervising new staff in that area.

While we fully understand the need to make sure Drs are suitably trained and supervised, in an area like ours, it puts a lot of pressure on everyone and additional costs when the medical council bring in these changes quickly with little consultation. We hope that we can all work together to help highlight these concerns and find effective solutions for all involved.

We are happy for you to use our situation as an example if discussing this with other authorities or government departments.

Yours sincerely
Irene Mosley – Recruitment Coordinator