Strengthening recertification for vocationally registered doctors

CONSULTATION FEEDBACK

Please complete the feedback form and return via email to: **recertificationconsultation@mcnz.org.nz**

Or by post to: Karen Davis
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Submission information				
This submission is on behalf of:	☐ Individual	☑ Group		
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The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

20 March 2017

Our ref: HMB17-224

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Dear Karen

Consultation on strengthening recertification for vocationally registered doctors

Thank you for the opportunity to provide feedback on the Medical Council of New Zealand's (the Council's) consultation on strengthening recertification for vocationally registered doctors. This work will have important implications for The Royal New Zealand College of General Practitioners (the College) and College members.

Executive summary

- The College is committed to improving its continuing professional development (CPD) programme to promote patient safety, better patient outcomes and practice improvement.
- Member feedback has formed the basis of this response and will continue to inform the College's direction of travel towards an improved CPD programme.
- The College supports the principles for recertification put forward by the Council in 2016. However, we are concerned that the proposal in this consultation document goes considerably beyond a principle-based approach. The requirements in the proposal are presented in a prescriptive manner which suggest that little flexibility, if any, will be allowed in interpretation. We are not clear whether this is the Council's intention and ask that this be clarified and flexibility incorporated where possible.
- The consultation paper does not make a clear distinction between the role of the Council as a regulator and the role of the College as an educational institution. It appears that the Council is devolving its responsibility as a regulator to the medical colleges. We suggest including the Council's role in recertification in the final document.
- The College's 2016 workforce survey showed that 22 percent of general practitioners (GPs) feel burnt-out. Our members are already under a large compliance burden, involving achievement of health targets, Primary Health Organisation (PHO) reporting, and practice accreditation processes and mandatory requirements. It is important that any new recertification requirements are not overly onerous, are simple to achieve and do not increase administrative or compliance loads. College members have indicated the potential for the requirements to drive GPs into early retirement. We are concerned that a major change to the programme could be the tipping point for the current critical workforce shortages in general practice.

- We are concerned that the evidence-base for proposals made in the document has not been presented. Where these proposals are far-reaching, this evidence is surely crucial. In particular, we consider that a full literature review should be included for the use and value of the professional development plan (PDP) in post-qualification continuing development programmes for professionals, the value of an annual conversation as a form of peer review, the value of the regular practice review (RPR) process in different scopes and contexts, and the basis for, and effects of, age differentiation.

- We ask the Council to note that the general practice context is significantly different from that of other medical specialties which are more procedural-focussed and/or based in a hospital context. Some elements of the proposal, if applied prescriptively, would not fit well in the general practice context.

- We are concerned about the level of resourcing (financial, workforce and time) that would be required to implement this proposal in its entirety.

- We are not sure what is intended by the reference to **qualitative** performance and outcome data. The language of the document and the specific measures suggested seems to favour quantitative measures. We ask the Council to note that quantitative measures are not easy to capture in general practice and are not widely available at the national level. In addition, we caution that an overreliance on quantitative measures may not lead to improvements in the quality of what is measured. If qualitative measures are what is intended, we suggest that the language of the document is amended to reflect this.

- We note that the proposal appears to be a move away from a system that is time based (ie sets minimum hours to be spent on activities each year). It would be useful if this was explicitly confirmed in the document.

- With regard to specific proposals in the document:

  – The College supports the ongoing use of audit of medical practice as a CPD programme requirement. However, we are not convinced of the value of, and are not ready to implement, any form of audit which relies on a national database of individual practitioner performance and outcome results. If this is what is required, considerable resources and planning would be needed.

  – The College's experience is that the multisource feedback (MSF) tool is valuable only in identifying outliers and not in providing data which will better inform members' professional development planning. We believe that MSF should remain optional in the recertification programme.

  – The College recognises the value of developmental and supportive collegial review. However, we would not support the creation of a process of annual external review with a regulatory function. We believe that flexibility needs to be built around the requirement for an 'annual structured conversation with a designated senior colleague'. Achievement of this requirement in its proposed form would not be easy within the context of general practice.

  – The College's experience with the PDP tool which is currently in use by our College has not been favourable. Although some members do find this tool valuable, the majority do not. However, it is possible that, in a new format, the tool could be more useful.

  – The College agrees that the medical colleges are the appropriate bodies for determining the knowledge requirements for their vocational scope. However, we point out that these requirements cannot be used in a 'tick box' sense to determine a 'standard of practice' in each curriculum area or for any possible presentation.

- We do not have any concerns about a requirement for RPR to be an option on recertification programmes. However, we point out that this may not be an appropriate tool in all contexts.
- The College agrees that providing additional and collegial support for its members is an important part of its function. However, we would be concerned if the Council is suggesting that the colleges bear responsibility for identifying those at risk and for putting in place remediation programmes in these instances.
- Our members do not support Council mandating specific requirements as doctors age, and the College is concerned that this may precipitate early retirement. We believe that the College has an important role to play in enabling and supporting older doctors who wish to stay in practice. This may include providing general guidance on strategies that can be used to self-regulate and to mitigate possible age-related risks. Beyond the provision of general guidance, however, the College is not convinced that individual career planning is an appropriate component of a recertification programme.
- The College agrees that a focus on continuing quality improvement is important and that colleges have a responsibility to ensure ongoing evaluation and review of their programmes.
- We do not agree that Council should be informed of the outcomes of RPR visits for all doctors. Council should be advised only in cases where substantial concerns have been identified.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end of life; and with the most inseparable intertwining of the biomedical and the psychosocial. GPs treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the College, is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- a greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- improved integration of primary, community, and secondary care health and social services which ensures the provision of high-quality services.

- universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- a review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

The Council's consultation

The Council is reviewing the current recertification requirements for vocationally registered doctors and is proposing new requirements and standards for the accreditation of medical colleges, which align with the Council's *Vision and Principles for Recertification*.

The Council's vision is that "Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support continuing improvement in performance." The principles, adopted following consultation in 2016, are that quality recertification activities should be:

- evidence based
- formative in nature
- informed by relevant data
- based in the doctor's actual work and workplace setting
- profession-led
- informed by public input and referenced to the Code of Consumers' Rights
- supported by employers.

The Council has explained that it has traditionally regarded CPD as the key mechanism for recertification. The Council now proposes new requirements to ensure the effectiveness of CPD on performance. The Council states that CPD is more effective when linked to baseline performance and when it addresses an individual doctor's learning needs. Further, that recertification programmes and activities should provide quality assurance and should support continuing improvement in performance.

The College's feedback

The College is committed to the development of a CPD programme which ensures the continuing competence of vocationally registered doctors and places high-quality equitable health outcomes and patient safety at the core. We are pleased to have the opportunity to work with the Council on developing the appropriate requirements for ensuring the continuing competence of doctors.

The Council will be aware that we have already been giving consideration to the College's CPD programme to ensure it is fit for purpose and aligned with the current understanding of best practice. We regularly survey our membership for feedback on programme requirements, most recently in 2016 when we received over 1500 responses. In January 2017, we notified College members of the Council's proposed recertification and invited feedback via a survey or directly to College staff. We received over 360 responses. This feedback has been valuable and will help to inform the College's direction of travel.

However, to better understand how the College's CPD programme can better meet the needs of our members while satisfying Council's set requirements, we intend to further engage with our members, PHOs and other relevant parties. We consider this engagement and our members' voice to be critical for the development of the College's CPD programme. We welcome the opportunity to work closely with the Council to ensure any proposed changes will meet the Council's requirements.

General comments

Principles-based approach

In 2016, the College supported the adoption of the Council's new principles for recertification programmes. Our understanding was that it would be the responsibility of the medical colleges to account for the manner in which their CPD programmes meet these criteria. At a meeting held on 20 February 2017 with College staff and in subsequent correspondence, the Council has confirmed that it is the Council's responsibility to establish a set of high-level principles, and that the content of the specific CPD programmes should be determined by the medical colleges as the 'subject matter experts'.

However, the College's view is that the current proposal goes considerably beyond the principles-based approach in terms of:

- setting additional requirements and responsibilities for colleges which may require considerable resourcing, place colleges in a difficult relationship with their members, and open colleges to the risk of legal action in cases where an individual member may have transgressed.
- setting specific requirements for the activities which must be included in recertification programmes.

We note that the language used throughout the document suggests that the requirements should be read prescriptively. It is not clear whether the prescriptive approach was the Council's intention, or whether there will be some flexibility allowed in interpretation. We suggest that if prescription is not the intent, the document is redrafted to show where flexibility may be applied. This applies throughout the document, but as an example, the document includes the requirement for the 'structured annual conversation with an external peer' as a 'minimum each year'. Does that annual minimum apply in all cases, or only in cases where other forms of external peer review are not operating?

It would be useful if the section in the document, 'Doctors registered in a vocational scope of practice' included a statement outlining the extent to which medical colleges are responsible for defining the recertification requirements in their scopes.

Role of the Council versus role of the College

The College draws the Council's attention to the differing roles played by the Council and the College. The Council's principal role as a regulator is to protect the health and safety of members of the public by determining who may practise medicine in New Zealand, and the conditions or requirements that pertain to this practice. Conversely, the College is a professional body and educational institute. As a professional body, the College's role is to represent member interests and advocate on their behalf. As an educational institution, the College provides programmes which enable specialisation and ongoing development in the scope of general practice.

The consultation paper does not make a clear distinction between these roles, and could be read to imply that the Council is devolving its responsibility of regulation to the medical colleges. We stress that the College does not have the same regulatory relationship with its members as the Council does, and cannot, nor wants to, act as a surrogate regulatory body.

The College understands that the proposal presented reflects a change of philosophy, from an understanding that participation in development and quality improvement activities can act as a proxy for competence, to a model where this competence must be assured (at a basic level through the tools suggested) in addition to requirements for participation in ongoing development and quality improvement activities.

We recognise that the Council wishes colleges to play a greater role in proactive identification and support of at-risk practitioners. However, the College considers that, while we do have a role in quality promotion, we are not a regulator. We are constrained in the actions we can take to assess members' 'risk' and to intervene

in individual cases. This is particularly the case since doctors, should they choose to do so, are able to withdraw from membership and practise within a general scope of practice. In addition, it is our view that more consideration is needed on the risks and legal ramifications associated with any transfer of responsibility for proactively identifying members 'at-risk' from the Council to the colleges.

The Council is uniquely placed to regulate recertification. We suggest that its role in this regard be made clear in the final document.

General practice workforce and burn-out

The College urges the Council to ensure that new recertification requirements are not more onerous than the current requirements.

There is currently a shortage of GPs across New Zealand, particularly in rural areas. This shortage is anticipated to grow over the next decade. We draw the Council's attention to the College's report, **Work & Wellbeing: Workforce Survey 2016**, which is attached as an Appendix and available on the College's website.

In particular, on page 17, the survey showed that 22 percent of GPs feel 'burnt-out' (n=1820): only 36 percent of respondents agreed that they usually had enough time to complete all their daily tasks (page 14 of the report).[1] The compliance burden arising from existing reporting requirements (national health targets, PHO reporting, and mandatory practice accreditation processes) is already very high. Member opinion is that the recertification requirements are also already onerous (taking personal time and funding) and concerns have been raised about increasing this burden of compliance.

The College takes these concerns seriously:

- An overly onerous recertification programme may be the tipping point that drives GPs into early retirement and exacerbates the looming critical workforce shortage in general practice.
- The more stringent requirements become, the more difficult it is for GPs to continue to provide services independently of the larger practices or employer organisations. This has implications for the provision of care, particularly in rural regions.
- Any changes to the programme which are perceived to be onerous could have implications for the relations the College has with members. Members have commented that they could opt to practise within a general scope of practice rather than maintain their Fellowship with the College. There could be long-term risks both to the College and to the quality of services provided in the sector if the proportion of non-vocationally registered doctors increased.
- An increase in compliance activities which are not directly related to improved patient care might have implications for the quality of the care provided.

Our members are already doing a huge amount with limited resources. Their CPD programme needs to be seen as a valuable contribution towards their professional development and to the quality of their practice. Excessive focus in recertification programmes on issues that serve a basic quality assurance function and are not a useful function for the vast majority of doctors is a poor use of resource. We stress the importance of finding a solution that does not over-burden doctors in its quest to ensure patient safety.

1 The Royal New Zealand College of General Practitioners. Work and Wellbeing: Workforce Survey 2016. Wellington: The Royal New Zealand College of General Practitioners; 2016.

We highlight some of the comments made by College members:

"I'm dismayed at the thought of more paperwork and likely higher compliance costs, which in general practice are ultimately passed on to patients, eg practice visits will cost money."

"If the process becomes too prescriptive or expensive, then it will undermine the College's current attempts to increase the general practice workforce and may force some excellent doctors into early retirement."

"These proposals are just more time consuming, draconian 'box ticking' exercises! Doubt very much that it will make for 'better doctors', but will probably drive some more experienced GPs out of practice"

"There is a fear and warning that older rural practitioners will get fed up with accreditation compliance and that this will contribute to a loss of staff in the sector that has a need to retain doctors."

"General practice is becoming more and more audit, performance data and guidelines driven. More and more time in the consulting day is spent staring at computers entering data and less time actually engaging with the person/patient. Continuing education should be driven by one's passion for medicine, the desire to be a better GP, to be stimulated by educating ourselves further in our particular interest and thus better serve our patients. The job is already stressful, additional auditing, performance reviews, peer reviews, endless hoops to jump through each year is yet another added stress. CPD is becoming more of an exhausting 'tick box' activity – I am not sure this equates to safer, better performing doctors."

"I think this is an intrusive and excessive attempt to control the practice of GPs in New Zealand and will lead to an exodus from the profession. I worked extremely hard to achieve Fellowship and I now feel like this is an enormous setback, the threat of constant pressure and surveillance and assessments when I have better things to do like trying to manage my 1500 patients. I can envisage GPs failing to perform their clinical duties because they have so many recertification tasks to complete."

"Making the whole process more arduous will be a negative for general practice. Also if more pressure is placed on 'ageing' GPs it may lead to more GPs opting out of or reducing their time in general practice which is not ideal considering we are supposed to be approaching a manpower crisis."

"We need to be mindful that we cannot expect GPs to do all of this stuff in their personal time. The whole business of 'self-care' is at stake here."

"I am not convinced data is accurate enough to inform learning needs."

Evidence-based approach

If the premise for the proposal is that an evidence-based approach to CPD activities improves performance, then the evidence for this proposal should be presented. We note the paucity of supporting evidence provided, and that full literature reviews, including recent evidence, are not cited. An evidence-based profession needs to be assured that the evidence behind the effectiveness of the proposal changes is robust.

In particular, we believe the full evidence base should be presented regarding the value of the professional development plan in post-qualification continuing development programmes for professionals, the value of an annual 'structured conversation', the value of the RPR process and the basis for and effects of age differentiation.

Context of general practice

The nature and context of general practice differs substantially from that of medical specialties which are procedural-focussed and/or based in a hospital context. Not all of the requirements within the proposal fit well within this context.

Differences include:

- The clinical scope of general practice is exceptionally broad. There is no simple procedural list that can be generated and against which specific audits can be created that would encompass this breadth.
- A key element of general practice is good communication in the context of a consultation. The fluid nature of this interaction is less amenable to quantitative measurement than is the case for procedural interventions.
- With the exception of prescribing data, there are currently no centralised datasets relating to the performance or outcomes of the individual practitioner in general practice.
- Collaboration and integration in primary care are important to achieving good patient outcomes. However, much of the clinical engagement in general practice happens in individual consultation 'behind closed doors'. There is the potential for practitioners to become isolated from peers even when situated in large practices. This is different from most hospital-based scopes. There is much higher value to be gained in general practice from initiatives that place emphasis on consultation review and discussion than in scopes where the 'consultation' is already team based and clinical decisions are taken in multidisciplinary meetings.
- Unlike doctors practising in secondary care, in many cases in general practice, the practice is owned by the doctors themselves. Except in the largest practices, there are often no clinical governance structures or clinical director positions within the practices themselves. Annual performance appraisal processes (as part of employment agreements) may not be used. This means that the requirements for an annual 'structured conversation with a designated senior colleague' could not be easily linked to existing processes.
- GPs are generally paid for clinical time only, with no funding provided for CPD activities, and no payment for the time spent achieving them. The cost to College members for participating in additional activities in terms of the financial cost and of time away from clinical practice must be taken into account. It is important to our members that a new recertification programme should not further disadvantage them. The implications of changes for small rural practices in particular should be given due consideration.
- The requirements for practice accreditation in general practice include compliance with minimum legal, regulatory and professional and standards. Responsibility for meeting these requirements falls largely onto individual practitioners. In a large hospital, this function would not typically be undertaken by clinicians. This results in a higher compliance burden in general practice.
- General practice varies in terms of clinical areas of focus, physical location (including remote practices and time spent internationally) and hours spent in practice (with a high proportion of doctors in locum positions). In addition, not all GPs are involved in providing clinical care to patients. Recertification requirements must be sufficiently flexible to cater for this breadth.
- The number of vocationally registered GPs is very high compared to the numbers in other scopes, and GPs are geographically very dispersed. This increases the costs of any proposed interventions, which may impact on rural, high-needs and Māori/Pasifika medical delivery.

Resourcing

The College's current CPD programme meets some of the Council's proposed requirements.

We use annual PDPs, which must be discussed with a colleague (this could be regarded as a reduced version of the proposed annual 'structured conversation'). RPR is provided on an optional basis. The College makes available CPD opportunities for members by means of providing access to a reputable international online learning system, by endorsing local providers and events and by providing a national conference and regional Faculty events for this purpose. An annual audit of medical practice is required, and the College provides a small number of self-audit templates as well as endorsing tools provided by other organisations for this purpose. The College encourages self-directed planned learning and reflection on learning activities. The College also provides an online facility for members to record their CPD activities, and monitors all members' compliance with CPD requirements.

However, under the proposal, it appears that the College's role would need to significantly increase. This includes the need to take responsibility "for assisting doctors to use performance and outcome data to identify professional development needs". We accept that the College should assist members to use this data to identify learning needs. However, we are concerned if it is the Council's intention that the College actively provides and monitors this outcome and performance data. Given that data is not readily available in general practice for this purpose, it would not be easy to comply with this requirement. Any development in this area would require considerable resourcing.

The College's role would also need to expand to include providing additional support for identified sets of doctors, and "supporting doctors to implement their PDPs". This seems to be a large step from the current situation where it is the doctor's professional responsibility to ensure that they undertake activities (which the College may have recommended, endorsed or provided) that will enable them to meet their PDP goals. We are unsure whether the College can provide individualised support for all doctors in this manner, and would not be able to do so without considerable investment of resources and possible costs to members.

RPR is expensive in the general practice context. CPD activities and time spent (in review or as reviewer) are not reimbursed by employers. If this initiative is expanded, there would be financial implications for our members. If the College is additionally required to have a nationwide set of 'designated senior colleagues' to provide external peer review for all members on an annual basis, costs to members (either directly or indirectly as a result of lost clinical time) will be large.

Outcomes and performance data

We find the language used in the proposal with regard to outcomes and performance data contradictory and confusing. Although the document refers to **qualitative** performance and outcomes data, the use of the term 'outcomes and performance data', as well as the specific measures given, suggest a more quantitative interpretation.

If the performance measures referred to are intended to be **qualitative**, we would suggest that the document be amended to refer to 'feedback on performance and outcomes'.

If the reference is, as it appears, to a more quantitative understanding of performance data, we note (as mentioned above) the difference between general practice and more procedural specialities. Performance and outcomes in general practice are not easy to measure or capture through quantitative data, and data at the level of the individual practitioner is not easily available.

In the latter case, we caution that:

- This will lead to a system which leans towards matters which are easy to measure, rather than those that may have a more substantial impact on quality. Overuse of the MSF tool is one such example.
- Care must always be used in the interpretation of data, since practice contexts and patient populations differ widely. Blanket comparisons of data, without reflection on the reasons that differences may exist, are not valuable.
- This may lead to additional compliance costs both directly to the practitioner and in terms of time required to be spent.

We recommend that the Council amend the document to make this requirement clear.

Recognised CPD

The proposal appears to be a move away from a system that is time based (ie sets minimum hours to be spent on activities each year). It would be useful if this was explicitly confirmed in the document: Will there be no specific time-based requirements set for the amount of CPD that must be attained in a year? The College would support this particular move. However, our members would not support a system where the new requirements are added to existing requirements. The implications for ensuring consistency between doctors and between CPD programmes would need to be considered.

The proposal does not specify the types of CPD that can be used to attain PDP goals. In the past, there have been suggestions that there is insufficient evidence on the value of activities such as conference attendance to justify their inclusion in recertification programmes. We do not see value in refusing to recognise these activities. Particularly in scopes where there is a risk of isolation, the value of opportunities to develop collegial and inter-professional links is high. These activities also present opportunities to hear about developments in areas that might not be of immediate clinical relevance (or captured in a pre-determined PDP) but which can lead to further educational activities or to the development of areas of interest. We note also that individual learning styles differ, and while participative activities may suit the majority, there are those for whom didactic sessions, appropriately reflected upon, are the best way to learn.

The College requests clarity

This proposal, and its apparent lack of flexibility, has led to questions and unease amongst our membership. The College strongly recommends that the Council take into account the feedback received and revise the proposal, ensuring that clarity is given on mandatory requirements and those that are more flexible, and provide a clear account of what is required or expected if they differ from current requirements.

Our response to the Council's questions

Set out below is the College's feedback to the specific questions raised in the consultation document.

Question 1

Proposal: Vocationally registered doctors must participate in an accredited recertification programme based on a set of requirements, including use of performance and outcome data to identify individual professional development needs.

Under the proposal, each doctor will need to use performance and outcome data, multisource feedback and external peer review to identify their professional development needs. Do you have any comments or feedback about the proposal that doctors' performance and outcome data should be used to inform the professional development plan? What is your view of medical colleges having to assist doctors to do this?

The College's current CPD programme includes some activities (eg audits of medical practice, the RPR process, some peer review activities) that provide doctors with feedback on their practice, and which can be used to further direct doctors' learning. While the College agrees that recertification programmes should include some evidence of feedback on individual performance in recertification requirements, we would caution against placing too much emphasis on data measurement.

As noted in our general comments, we believe such a recertification model risks stressing activities that are easy to measure, rather than those activities which are meaningful for the doctor's professional development or which encourage significant improvements in practice.

We also note that outcome data for individual practitioners in the form of quantitative datasets are not easily available, that there is no national consistency in data and that results can be subject to misinterpretation.

We asked College members if they agreed that recertification activities should be based on doctors' performance and outcome data. Overall, of 354 respondents, 49 percent disagreed with the proposal of using performance and outcome data (including MSF and external peer review) to identify a doctor's professional development needs. Only 26 percent of respondents agreed with this proposal.

Some of the feedback we received is as follows:

> *"Performance and outcome data are difficult to obtain, hard to apply to a very generalist doctor, and hard to analyse for general practice."*
>
> *"Current measures of outcome are difficult to use and are too blunt and inaccurate to measure true quality."*
>
> *"Does not take into account socio-economic factors impacting on patient care, mobility of the population and hard to reach communities."*
>
> *"It is likely to be biased towards measurable targets."*
>
> *"Outcome data risks driving and skewing behaviour to a tick box exercise of limited value."*
>
> *"Outcome data advantages doctors working in well-off populations with lots of resources and could have a negative effect on health equity."*

Set out below is specific feedback on using the outcomes from audit, results from MSF and feedback from a review undertaken by external peers in the recertification requirements.

a. Audit

Current Council requirements for CPD include the requirement for an annual audit activity. The Council's definition of an audit of medical practice is "a systematic, critical analysis of the quality of the doctor's own practice that is used to improve clinical care and/or health outcomes or to confirm that current management is consistent with the current available evidence or accepted consensus guidelines". The criteria for conducting an audit of medical practice are specified by the Council.

Currently, GPs fulfil this requirement by undertaking organisational audits approved by the College, or by devising audits relevant to their own practice. We support continuing this requirement. However, we note that:

- This requirement is particularly difficult for locum doctors who do not have access to their own patient base to audit.
- There are many audits that are conducted in general practice that are focussed at organisational or practice level. These do not identify individual practitioner outcomes and are currently recognised for CPD purposes only if combined with individual reflection and development plans.

It would help if the Council clarifies whether anything further than this is intended in the new proposal. One reading of the document is that a specific audit tool (or tools) must be created by colleges against which doctor performance is monitored. Whilst this may be possible in more procedural scopes (with specific outcome expectations set for specific procedures), it would be difficult to adopt such an approach in general practice, where the range of potential audit topics is broad, where outcomes are not easy to measure, and where patient presentations are complex and often unique.

The College is not currently involved in data collection, either for the existing audits undertaken by doctors, or of health system data which would enable national audits to be created (although there are instances where specific PHOs are able to provide this level of data to their doctors). The only data available nationally to all members (although not directly to the College) are the prescription reports currently produced by bpac^{nz} (the results of which need contextual interpretation). If this is what the Council has in mind, this area would need considerable development by the College.

We note again that the range of general practice knowledge is very broad and largely non-procedural. We note that it is unlikely that tools could be developed that would be sufficiently comprehensive to identify all possible skill areas and content areas for updating.

b. Multisource feedback

The College has, for more than 20 years, offered a patient satisfaction tool for practitioner use and has recommended a colleague feedback survey available internationally. These tools are compulsory within the training programme, and are optional for Fellows on the CPD programme. A patient survey is also required three-yearly in the *Aiming for Excellence* accreditation processes for general practices. In 2016, the College piloted a new version of MSF based on the General Medical Council tool (as recommended by the Council). This tool has unfortunately proved to be too administratively intensive for a large-scale roll out.

Our experience, based on analysis of data and feedback on these tools, is that, whilst they are useful to identify doctors whose practice is considerably below the norm, results tend to cluster at the very high end of the scale (with a very high majority of doctors attaining ratings of 94 percent and above). Thus, results are non-discriminatory. In addition, the simplicity of the questions asked does not, on the whole, allow for the identification of specific areas to inform professional development planning. The value of the tool lies in its ability to identify outliers and not (except when used as part of a structured training programme) in its ability to enrich professional development.

Specifically with regard to the use of the colleague feedback tool, the College is concerned that:

- There is potential for adverse consequences on collegiality in small regions if negative comments are received.
- Survey fatigue will result if the MSF tool is required to be used regularly by all doctors. In particular, in rural areas and small towns, people are likely to be selected as survey respondents multiple times.
- This tool will also be difficult to use for those doctors working in a non-traditional settings.

We note that there is already a tool for collecting patient experiences in general practice, which will be part of the mandatory Foundation Standard requirements for all general practices (the Patient Experience Survey provided by the Health Quality and Safety Commission). Although this tool does not provide data at the level of the individual practitioner, and therefore is not suitable for CPD purposes, it does ensure that patient feedback on practice is taken into account.

The College believes that the use of MSF tool should remain optional in the recertification programme. Member opinion is strongly against compulsory introduction (48 percent disagree versus 27 percent agree).

c. Peer review

The College's current CPD programme requires the completion of a set number of peer review hours, which is usually met by our members through attendance at peer group meetings at which cases are discussed. Although there may be variation in how peer groups currently function, College members consider their peer groups to be enjoyable, supportive and to contribute positively towards professional development. They find discussion of cases in these groups to be one of the best ways for learning and identifying further learning needs.

It does not appear that College peer review groups would be sufficient to meet the proposed new requirements for 'a review undertaken by an external peer'. We note the value doctors gain by meeting with a group of peers in a supportive environment where they feel safe to raise concerns. In general practice, the peer groups serve a vital function in counteracting isolation and we would not favour changes that may undermine their continuance. (We understand that peer review groups could be continued as an optional or College-required activity, but would be concerned that this requirement, in addition to those proposed by the Council, would be overly onerous for members).

We note the similarity between this proposal and the requirement in the United Kingdom for annual appraisal by an external appraiser. This is a highly regulatory process. If this is what is intended by the proposal, the College is not convinced of the value that such a process would bring: the insight that the external person will have into the doctor's practice (in the absence of a full RPR-type process) will be minimal.

We note again that that there are seldom clinical governance structures or clinical director positions within a general practice, and that annual performance appraisal processes are not common. This means that this requirement could not be easily linked to existing processes. Costs to implement this proposal would be very high, and, if the focus is regulatory rather than developmental, should not be worn by our members, either directly, or in terms of the time that will be required to be spent. Our members have indicated a strong disagreement with this proposal (60 percent disagreed versus 19 percent agreed).

However, the College does recognise the value of developmental and supportive collegial review. As the Council is aware, feedback from the RPR option that the College offers has been very positive. In addition, an annual conversation with a peer (along the lines of the current PDP discussion) or discussion of a reflective learning portfolio and development plans in a peer group may be more palatable to our members.

Question 2

Proposal: Vocationally registered doctors must develop an individualised Professional Development Plan (PDP) targeted to their identified professional development needs.

Do you have any comments or feedback about the proposal that an individualised PDP for each doctor should form a central part of recertification and that doctors will be expected to review their own PDP each year?

The College's current CPD programme has included a requirement for an annual PDP (which must be signed off by a colleague) for the last six years. Our experience with this requirement has not been positive:

- Although some members get value out of use of this tool, the majority do not see value in trying to specify their learning needs for the year at a single point of time. We are aware that many are completing their plans at the end of the year, adapted to reflect the activities they have already undertaken.
- The manner in which the PDP is currently used requires doctors to identify a small number of goals for the year. Specification of goals in this manner is intended to encourage goal achievement (although the effectiveness of this strategy has not been researched in this context). However, the plan does not in any way reflect the vast body of learning that GPs engage in on a daily basis.
- Our members report that they become aware of learning needs on the basis of specific patient presentations. Some use systems such as a discomfort log as a means to organise their thoughts and plan their learning. Others address identified needs immediately through access to online resources. Members have reported that they see the need to log in to a system to specify goals in advance of this learning to be overly bureaucratic and compliance focussed.

We accept that the specific manner in which our current PDP works may not be ideal for its purpose, and that there may be more effective ways of creating PDPs. We also suggest that other means can be found to achieve the same goals. For example, using reflective learning portfolios as a basis for a peer discussion about future learning plans, and using other technological solutions to lower the administrative burden associated with this requirement.

Whilst the College is not strongly averse to continuing the PDP requirement in some form, we have found little evidence to support the use of learning plans for CPD purposes (ie outside of structured qualifications) in complex professional fields, and request that the Council make available the evidence and research on which it bases this proposal.

Comments from College members included:

> *"I do not believe that the proposal takes into consideration the amount of 'ad hoc' learning we undertake on an almost daily basis. In general practice one never knows quite who or what problem is going to walk through the door. Very often I will find myself refreshing my memory about a disease process heard about long ago in Med School or researching a patient's newly made diagnosis. One cannot 'plan' this sort of learning but it is still 'learning' just the same!"*

> *"It is important to reflect on professional development needs, but the current process of writing a PDP is not always useful as needs can change during the year."*

> *"A PDP is surely a personal plan for an individual. If you make it part of recertification you will surely get plans that are written to impress. A plan is not evidence of safety. In many cases a plan may genuinely identify learning needs but if there is a significant deficit that would indicate a significant deficiency I suspect it may not appear in the plan. It may be worked on in private instead."*

"PDPs have made me think on what I want to know. It clarifies my mind. It should not be onerous, ie not more than three or four goals though, or I will continually pick that I want to make an exit plan!"

"For a well-functioning doctor this is an interative process based on day to day needs – not a preplanned schedule of annual expectations. This would have all the value and effectiveness of drunken new year resolutions."

"Where is the evidence for this?"

Question 3

Proposal: Each medical college is responsible for defining the knowledge requirements for their vocational scope(s) of practice and incorporating these into their recertification programmes. These must reflect expected standards of medical practice, including those outlined in Council's statements, Good Medical Practice, Council's domains of competence, cultural competence, and the Code of Health and Disability Services Consumers' Rights.

What is your view of medical colleges defining knowledge requirements?

The College agrees that the medical colleges are the appropriate bodies for determining the knowledge requirements for their vocational scope.

The knowledge requirements for general practice are currently described in the *Curriculum for General Practice* (the Curriculum). Core competencies are listed in in six domains (which map to the Council's domains), and specific competencies are listed in each of 31 curriculum areas.

Legislative requirements such as the Code of Health and Disability Services Consumers' Rights and other pieces of legislation fundamental to general practice in New Zealand are included in the general practice *Aiming for Excellence* Standard and practice accreditation process. There is already a system of regulation ensuring that these requirements are met in general practice and the College sees little value in repeating compliance requirements.

The Curriculum, with its domains, curriculum areas and core and specific competencies can be used as a means for Fellows to check their knowledge and to provide ideas for areas in which they may wish to upskill.

However, the complexity and breadth of scope described in the Curriculum mean that it cannot be used in a 'tick box' sense to determine a 'standard of practice' in each curriculum area or for any possible presentation. We assume that that is not what the document intends.

Members have commented that they do not understand this paragraph in the proposal, and would not support any kind of regular 'examination' if that is what is intended.

Question 4

Proposal: Regular Practice Review (RPR) is provided by the medical college as an option for their doctors to undertake on a voluntary basis.

Do you have any feedback – concerns or particular benefits you envisage – related to the proposal that each medical college is required to develop and provide RPR as an option for doctors within their recertification?

RPR is currently offered as an option within the College CPD programme. Although participant numbers have not been high. Feedback on this process from those who have been involved has been good. Members have indicated that they support this being an option in the programme (44 percent agree versus 22 percent

disagree). However, they point to the logistical difficulties and costs that would be involved in a more widespread adoption of this option.

We would like to draw the Council's attention to the fact that RPR may not be an appropriate tool in all contexts. The pilot that has recently been conducted on an RPR process in our rural hospital medicine division has highlighted that there is much less value to be gained in that context: rural hospital doctors tend to work in open, team-based environments. A visit from an external peer thus provides less benefit than it does in the relative isolation of general practice.

Some of College members' comments were:

> *"I found this a useful process."*
>
> *"Cost is a big factor? Who is going to pay for this?"*
>
> *"Some people might prefer this but it takes doctors away for general practice to assess and would cost so I don't think it should be compulsory. Would be good to assess doctors where there is concern over their performance."*

Question 5

Proposal: Medical colleges will provide additional support for doctors when required. When identifying an individual doctor's professional development needs, consideration must be given to the knowledge of the doctor, the stage of progression in their career, their work requirements and other factors that can influence the performance of a doctor.

Do you have feedback about providing additional support for doctors depending on their individual professional development needs?

The College agrees that providing additional and collegial support for its members is an important part of its function. However, we do not believe that it is the College's role, or that the College has the capacity, to assess and identify the professional development needs of individual doctors. We see it as appropriate that we provide a system in which doctors are encouraged to identify their own learning needs and enabled, where possible, to address them. Where necessary, the College can offer specific support to individuals who have requested it, or who have been directed to us through other means (such as Council processes). However, the expectation should not be that a similarly individual approach will be taken to all members. This would be beyond our capacity.

We would be concerned if what is being suggested is that the medical colleges bear legal responsibility for identification of those at risk, and for putting in place remediation programmes in these instances.

College members' feedback included:

> *"It sounds like a good idea but how would you do this? How many members do we have? How would this be administered? Sounds as if the only real outcome would be a great increase in College fees to cover this."*
>
> *"I agree that our College is obliged to assist our profession in any and all ways to ensure that individual practitioners are doing well professionally and personally in our profession. I do not agree, however, that this means it would also be great if all our members had to keep proving that they are current and safe in their practice to this degree."*

Question 6

Career management planning is recommended for all doctors. Should Council mandate certain activities as doctors age? If so, what activities and what age should apply?

We note Steven Lillis and Eleanor Milligan state: "The best protection for all is not to further stigmatise ageing, but to have a robust and independent process of ensuring ongoing fitness to practice, which requires **doctors of all ages** to demonstrate that they have the requisite 'inherent' skills to practice medicine safely."[2] [emphasis added]

College members have taken strong offence to the suggestion that Council should mandate certain activities as doctors age (62 percent disagree versus 16 percent agree). They have pointed to the fact that age is a prohibited ground for discrimination under section 21(1)(i) of the Human Rights Act 1993. Members suggested that such discrimination would go against the principle of using evidence-based assessment of training and development as a basis for CPD. They have further pointed to the fact that the evidence for such a proposal is not robust.

The College is concerned that a large proportion of its current workforce is in the older brackets and that this section of the workforce is essential to the health system, both in terms of service provision and in the contribution provided to the profession. Additional requirements set for the ageing doctor may encourage doctors in these age brackets to retire early. Given the looming crisis in workforce numbers in general practice, the older cohort of GPs must be retained unless clear evidence is provided that ageing doctors in general practice present a risk of harm to patients.

Since age does not necessarily mean a change in competence on all tasks and for all doctors, there may be better ways of addressing age-related changes than via recertification. The College considers that it has an important role to play in enabling and supporting older doctors who wish to stay in practice. For example, support might include providing information on age-related potential cognitive changes and general guidance on strategies to self-regulate and mitigate risks.

However, because of the lack of evidence of harm and the potential and serious workforce implications, the College is not convinced that this is an appropriate component of a recertification programme.

Comments from College members included:

> *"This is discrimination and I am sure would be in breach of NZ law. The need for certain activities (or not) should be determined by competencies not age. (If we accept that age should determine the need for specific activities, is gender or ethnicity next on the list?)"*

> *"We should offer career management planning to all of us, regardless of age."*

> *"Discriminatory. Ignores an individual doctor's self-awareness and self-management as they age. Age alone is certainly not a good marker for an individual GPs competence."*

> *"There is difference between age and competence and the loss of older rural GPs will result in a collapse in primary care services in the regions."*

2 Lillis S, Milligan E. Ageing Doctors. Australas J Ageing. 2017 Jan 25. doi: 10.1111/ajag.12371.

Question 7

Proposal: Medical colleges collect and analyse data to undertake an evaluation of the recertification programme to support continuous quality improvement.

Under the proposal, each medical college is responsible for collecting and analysing data for the purpose of undertaking an evaluation of the recertification programme and supporting continuous quality improvement. What feedback do you have on the requirements for continuous quality improvement?

The College agrees that a focus on continuing quality improvement is important and that the colleges have a responsibility to ensure ongoing evaluation and review of their programmes. We note, however, that effectiveness, except with regard to levels of participation and engagement, is not easy to define or measure.

Question 8

Do you have any general comments or feedback on the Council's proposal to set standards for recertification programmes that align with its vision and principles for recertification?

Please see our general responses above.

In addition, with regard to paragraph 10(e) in the consultation document, we do not agree that Council should be informed of the outcomes of RPR visits for all doctors. This is not currently the requirement, and will bring a draconian flavour to what, in general practice, is a strongly collegial and developmental activity. It will act as a disincentive for doctors to participate in an optional scheme. However, we do agree that if concerns are identified in the course of an RPR visit, and these concerns are of a substantial nature, that Council should be made aware of the issue. As is currently the case, we would expect Council to instigate its own investigation process in this instance, with RPR reports remaining confidential within the College.

Question 9

Do you foresee any barriers or challenges to implementation of the proposed recertification model and if so, what are they? Can you suggest any solutions to address these issues?

There is currently no requirement that doctors in the general practice CPD programme should base their professional development activities on performance and outcome data. As discussed above, this data is not readily available at the system level in general practice.

It is likely that the resource implications for the College of the introduction any new requirements will be substantial (and will involve development of systems, technology and people). An increased financial burden is not likely to be well received by members.

Member opinion is that CPD requirements are already onerous (taking personal time and funding) and that additional requirements will not necessarily lead to better patient care. Additional bureaucratic requirements will not be welcomed.

Question 10

Is three years from Council's decision an appropriate and/or practical transition period for implementation of new recertification requirements?

The College believes that time will be needed to develop a CPD programme that meets any new Council requirements, as well as to develop any new tools and resources necessary. Time will also be crucial to consult with our members, and to socialise and implement a new programme. We agree that adequate time must be allowed.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at **policy@rnzcgp.org.nz**.

Yours sincerely

Helen Morgan-Banda
Chief Executive

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

GP
Heart of the community
Kāinga Tupu

Work & Wellbeing

Workforce Survey 2016

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The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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FOREWORD

One of The Royal New Zealand College of General Practitioners' strategic pillars relates to protecting and enhancing our GP workforce. To ensure New Zealand continues to recruit and retain high-quality GPs, the College needs to understand its members' concerns, needs and career intentions.

To this end, for the past three years, the College has undertaken an annual workforce survey to help us analyse the shape of our current and future workforce. This year, we contracted Research New Zealand to collate and analyse the results on our behalf. The 2016 survey covered issues not explored previously, including attitudes to practice ownership, the use of technology, GP wellbeing and time spent on various activities.

The 1820 valid responses were analysed, and this data has given us insights into these new topics and up-to-date information on crucial issues such as retirement intentions, vacancies and income, which is not collected in any other national survey. This year, we've spread the survey results over five individual reports.

This report, Work and Wellbeing, is the first to be published. It looks at the hours members work (approximately half work part-time) and analyses how their time is spent. As expected, much of a GP's work involves face-to-face consultations, but we also investigated how much time is given to paperwork and after-hours practice. In addition, we asked about the employment and voluntary commitments members have outside of their practice that relate to their expertise as doctors.

Reassuringly, most GPs responded positively when asked how likely it was that they would recommend a career in general practice. The majority of GPs felt motivated and involved in general practice and believed that they had a good work-life balance.

Despite the busyness of our working lives and the daily challenges of caring for a growing (and ageing) population, this report gives me confidence that, across the country, most respondents find being a GP a rewarding speciality. That said, general practice and GPs need to continue to be supported through adequate funding so patients can see them when they need to and we can train the next generation of GPs.

I'd like to thank everyone who participated in this survey. It's a valuable resource that will help us better serve our members.

Dr Tim Malloy

RNZCGP President

INTRODUCTION

There is great variety in New Zealand general practice. Individual general practitioners vary considerably in the hours they work and the number of patients they see. One-half of GPs (49 percent) work part-time in general practice.[1] Female GPs are twice as likely to work part-time as male GPs (63 percent compared with 32 percent).

Two-thirds of GPs have after-hours general practice commitments (66 percent), with 36 percent of all GPs having these commitments as often as every week or every second week.

The term 'part-time' can be misleading when applied to general practitioners, as 42 percent of all GPs report that they also have work or other commitments (outside of their general practice work) that relate to their expertise as a doctor. This includes time spent working for public or private organisations in an advisory or assessor capacity, and lecturing in tertiary education settings, as well as spending time organising or participating in community or cultural activities, meetings or hui (in a health-related capacity).

In general, as well as reporting longer general practice hours and more face-to-face patient consultations in the average week, male GPs report greater after-hours general practice commitments and more time spent on work or other commitments outside general practice than their female counterparts. Working hours also differ by other factors, in particular by age and rurality.

Those GPs who work longer hours are also more likely to report feeling 'burnt-out'. GPs aged 40-64 years, owners/partners and those GPs who work in a practice that currently has a vacancy for a doctor are all also more likely to report feeling 'burnt-out'.

Overall, 22 percent of survey respondents self-reported as being 'burnt-out'. 'Burn-out' is associated with poorer self-reported health status, as well as less propensity to continue to work in general practice.

This year's survey also investigated GPs' general attitudes towards general practice. It is reassuring to find that most GPs would recommend general practice as a career. Most GPs feel motivated and involved in general practice, they feel that they can rely on their colleagues for help and support, and they believe that they have a good work-life balance. However, only about one-third (36 percent) of GPs feel that they have enough time to complete all of their daily tasks.

For the first time, the survey also investigated incidents of bullying, discrimination and sexual harassment in general practice. The majority (82 percent) of GPs had not personally experienced bullying, discrimination or sexual harassment from a health sector colleague in the past 12 months. However, 11 percent of GPs reported experiencing bullying, seven percent reported experiencing discrimination and one percent reported experiencing sexual harassment. Female GPs were slightly more likely to report incidents of bullying, discrimination or sexual harassment than male GPs. The rates experienced by registrars, overseas-trained GPs and Māori GPs are largely reflective of the rates experienced by all GPs.

1 For the purposes of the survey 'working part-time' is defined as working less than 36 hours per week and includes time spent conducting face-to-face consultations as well the time spent on paperwork, practice management, teaching, and time actually worked when on call.

The incidence of 'burn-out' and bullying in general practice are of particular concern, and these are issues that the College will need to address. Some action is already under way. The College has recently revised its self-care resource to better support GPs who experience 'burn-out', bullying and other factors that impact on their wellbeing. In addition, we are taking steps to better allow the College to report and act on bullying of registrars. We will also be looking at other ways we can better protect GPs, and ensure they remain safe and well in their practice.

HOURS SPENT WORKING IN GENERAL PRACTICE

Half of all GPs spend less than 36 hours per week working in general practice

There is wide variation in the hours worked per week by GPs. However, one-half of GPs (51 percent) say they spend 36 hours or more in the average week working in general practice, with the remaining 49 percent working part-time (Table 1).

For the purposes of the survey, 'working part-time' is defined as working less than 36 hours per week and includes time spent conducting face-to-face consultations, as well as time spent on paperwork, practice management, teaching, and time actually worked when on call, or providing after-hours care, but not the time spent on any medical work outside of general practice.

The number of hours worked in general practice per week varies significantly by gender. Two-thirds (67 percent) of male GPs report they usually spend 36 hours or more working in general practice per week, compared with 36 percent of female GPs.

Table 1: Total hours worked in general practice per week (n=1,820)

Q3 Which one of the following best represents the total hours per week you usually work in general practice?

Unweighted base =	All GPs 1,820 %	Male GPs 824 %	Female GPs 976 %
1-10 hours per week	4	4	4
11-20 hours	12	7	16
21-30 hours	18	8	26
31-35 hours	15	13	17
36-40 hours	18	20	16
41-45 hours	13	17	10
46-50 hours	8	12	5
51-55 hours	5	7	2
56-60 hours	4	6	2
61 hours or more	3	5	1
Don't know	0	0	0
Total	**100**	**100**	**100**
Mean (hours spent working in general practice per week)	35	39	31

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

TIME SPENT DOING FACE-TO-FACE CONSULTATIONS AND PAPERWORK

The majority of a GP's working week is spent in face-to-face consultations

GPs working 36-40 hours per week were estimated to spend a mean of 29 hours per week in face-to-face consultations. There was little difference between male and female GPs, although the proportion of time spent on face-to-face consultations was slightly higher among male GPs (79 percent) than female GPs (76 percent) (Table 2).

The estimated mean number of face-to-face consultations per week was also higher for male GPs (102 consultations) than female GPs (87 consultations). The estimated mean number of consultations per hour was 3.3 per hour and again this was higher for male GPs (3.4 per hour) than for female GPs (3.0 per hour).

Some of this gender difference may result from the hours worked by female GPs tending to be towards the lower end of the 36-40 hour range compared with male GPs. This was noted in the 2015 survey where respondents had the opportunity to provide actual hours worked in addition to selecting the appropriate hours range.

Table 2: Hours spent consulting and number of face-to-face consultations per week (n=1,820)

	Estimated mean hours consulting per week	Estimated mean hours consulting per week as a % of total hours worked	Mean number of face-to-face consultations per week	Estimated mean consultations per hour consulting	Number of respondents
Male respondents	30	79	102	3.4	157
Female respondents	29	76	87	3.0	139
All respondents	**29**	**76**	**95**	**3.3**	**298**

Source: RNZCGP-Workforce Survey, 2016.

One-half of GPs spend at least five hours per week on patient-related paperwork

GPs were asked about the time they spent on the following activities: patient-related paperwork; liaising with other health providers; continuing professional development; teaching medical students or registrars; and practice management (e.g. dealing with staff).

Patient-related paperwork was the most time-consuming of these tasks, with almost one-half of GPs stating that they spend six hours or more on this task (43 percent) (Table 3). GPs working 36-40 hours per week were estimated to spend a mean of 5.3 hours per week on paperwork.

The estimated proportion of the week spent on paperwork was slightly higher among those working fewer hours per week. GPs working 36-40 hours per week spent an estimated 14 percent of their time on paperwork compared with an estimated 18 percent spent by those working 21-30 hours per week.

Table 3: Total hours spent on patient-related paperwork per week, by hours worked in general practice per week (n=1,820)

Q6. How much time per week do you spend on patient-related paperwork?

Hours spent on patient related paperwork per week	Hours worked per week (Unweighted base)						
	All GPs (1,820) %	1-20 (296) %	21-30 (328) %	31-35 (269) %	36-40 (324) %	41-50 (395) %	51 or more (205) %
Up to 1 hour	6	15	4	6	4	4	0
2 hrs	14	28	15	8	11	12	7
3 hrs	14	21	17	16	13	11	8
4 hrs	13	14	17	16	15	10	4
5 hrs	10	7	12	9	15	8	7
6 hrs	12	6	16	15	12	13	8
7 hrs	5	3	6	5	6	4	5
8 hrs	8	2	5	11	10	11	12
9 hrs	3	1	2	3	1	4	6
10 hrs or more	15	2	4	10	13	24	43
No time spent on this activity	0	1	0	0	0	0	0
Don't know	0	0	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Mean (hours spent on patient related paperwork per week)	5.3	3.2	4.6	5.3	5.3	6.2	7.7

Total may not sum to 100% due to rounding.

AFTER-HOURS COMMITMENTS

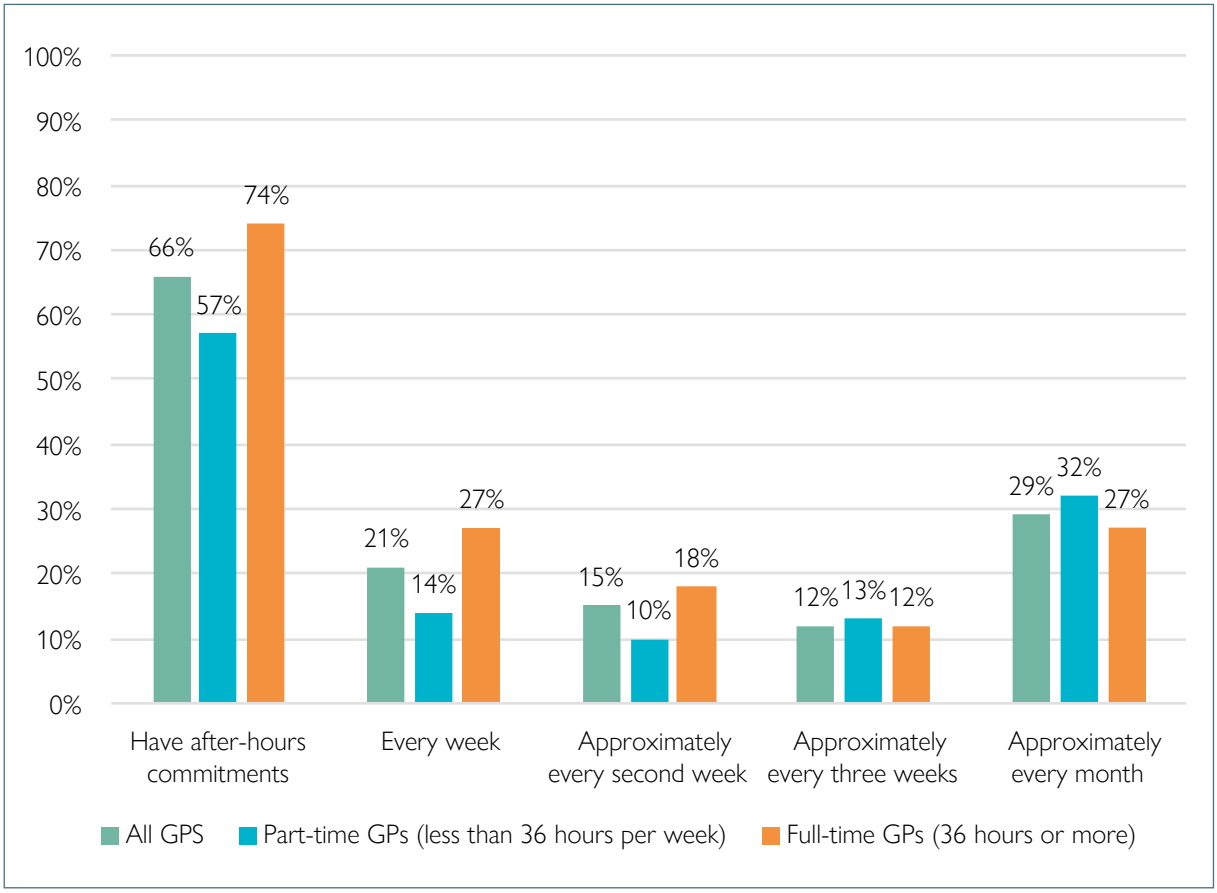
Many GPs have after-hours general practice commitments

GPs working full-time were more likely than GPs working part-time to have after-hours general practice commitments to provide acute care (74 percent and 57 percent respectively) (Figure 1).

Male and female GPs working full-time are as likely as each other to report they have after-hours general practice commitments to provide acute care (75 percent and 73 percent respectively).

Figure 1: After-hours general practice commitments, by full-time/part-time weekly status (n=1,820)

Q7. Do you have any after-hours general practice commitments to provide acute care?



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

After-hours general practice commitments also vary depending on whether the GP is working in an urban practice or a rural practice. As shown in Table 4, when GPs working full-time are compared, rural GPs are more likely to have after-hours commitments than their urban-based counterparts (83 percent and 71 percent respectively).

Table 4: After-hours general practice commitments by full-time GPs, by urban or rural based (n=923*)

Q7. Do you have any after-hours general practice commitments to provide acute care?

Unweighted base =	Full-time GPs (36 hours or more) 923* %	Urban 652 %	Rural 170 %	Not clearly urban or rural 101 %
No	26	29	17	20
Yes	74	71	83	80
Total	**100**	**100**	**100**	**100**
Unweighted base =	**686****	**464**	**141**	**81**
Every week	27	20	52	19
Approximately every second week	18	17	21	22
Approximately every three weeks	12	14	5	12
Approximately every month	27	30	14	27
Less frequently than monthly	16	18	9	20
Total	**100**	**100**	**100**	**100**

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

**Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more) and have after-hours general practice commitments.

Furthermore, when the frequency of after-hours commitments is considered, the heavier load on rural GPs becomes even more evident. Among full-time rural GPs who reported having after-hours commitments, 52 percent stated they had after-hours commitments every week, compared with 20 percent of urban GPs.

OTHER PAID OR VOLUNTARY ACTIVITIES

In addition to their general practice work, many GPs also engage in other paid or voluntary activities that relate to their expertise as a doctor

Forty-two percent of all GPs report that they spend time on other activities (outside of their general practice work) that relate to their expertise as a doctor. This includes work for organisations such as the Ministry of Health, district health boards, ACC, Medical Council of New Zealand, universities, insurance companies or the College and they also do work, which is often voluntary, organising or participating in health-related community or cultural activities, meetings or hui.

Table 5 shows that most GPs spending time on these other activities spend less than six hours per week (62 percent). However, GPs working part-time who spend time on such activities are more likely to spend more than 10 hours per week on such activities (32 percent) compared with full-time GPs (eight percent).

Table 5: Time spent on non-general practice activities per week, by full-time/part-time weekly status (n=1,820)

Q9. On average, about how many hours per week, in total, do you usually spend doing these activities?

Unweighted base =	All GPs 1,820 %	Part-time GPs (less than 36 hours per week) 893 %	Full-time GPs (36 hours or more) 924 %
No non-general practice activities	58	59	57
Spend time each week on non-general practice:	42	41	43
Total	**100**	**100**	**100**
Unweighted base =	**767***	**369**	**396**
• Up to 5 hours per week	62	51	73
• 6-10 hours	15	15	15
• 11-15 hours	5	8	2
• 16-20 hours	5	7	2
• 21-25 hours	3	5	1
• 26-30 hours	2	4	1
• 31-35 hours	2	4	1
• More than 35 hours	2	4	1
• Don't know	4	3	5
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who spend time on non-general practice activities each week.

The extent to which GPs spend time on these activities also varies by gender. Full-time male GPs are more likely than full-time female GPs to engage in such activities (46 percent and 38 percent respectively) (Table 6).

Table 6: Time spent on non-general practice activities per week by full-time GPs, by gender (n=924*)

Q9. On average, about how many hours per week, in total, do you usually spend doing these activities?

Unweighted base =	Full-time GPs (36 hours or more) 924* %	Male GPs 559 %	Female GPs 355 %
No non-general practice activities	57	54	62
Spend time each week on non-general practice:	43	46	38
Total	**100**	**100**	**100**
Unweighted base =	**396****	**257**	**136**
• Up to 5 hours per week	73	74	71
• 6-10 hours	15	16	14
• 11-15 hours	2	2	2
• 16-20 hours	2	2	3
• 21-25 hours	1	1	1
• 26-30 hours	1	1	0
• 31-35 hours	1	1	0
• More than 35 hours	1	0	1
• Don't know	5	2	8
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

**Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more) and spend time on non-general practice activities each week.

MOTIVATION AND INVOLVEMENT IN GENERAL PRACTICE

GPs feel motivated and involved in general practice, and most would recommend it as a career

This year's survey also investigated GPs' attitudes towards general practice, with the results showing more than three-quarters of GPs agreed they were motivated and involved in general practice (78 percent) (Table 7).

Eighty-one percent agreed that they could rely on their colleagues for help and support. However, much smaller proportions felt they had good work-life balance (58 percent) and that they have enough time to complete all their daily tasks (36 percent). Overall, nearly three-quarters would recommend a career in general practice (73 percent).

For the first time, the survey also investigated incidents of bullying, discrimination and sexual harassment in general practice. The majority of GPs (82 percent) had not personally experienced bullying, discrimination or sexual harassment from a health sector colleague in the past 12 months. However, 11 percent of GPs reported experiencing bullying, seven percent reported experiencing discrimination and one percent reported experiencing sexual harassment.

Registrars, GPs who qualified overseas and GPs who identify as Māori are as likely as other groups of GPs to report rates of bullying, discrimination or sexual harassment. On the other hand, GPs who work in rural general practices are more likely than those working in urban-based general practices to state they have been bullied.

Tables 7, 8 and 9 present these results by age, location and gender. There are significant differences by age, with GPs aged 40-64 years recording less positive results than those aged 25-39 years, and those aged 65 years and over on many of these questions.

For example, 74 percent of GPs aged 40-64 years felt motivated and involved in general practice and 79 percent could rely on their colleagues for help and support, which is significantly fewer than younger GPs aged 25-39 years (85 percent and 88 percent respectively).

GPs aged 40-64 years were also less likely to feel they had good work-life balance (53 percent) and enough time to complete all their daily tasks (32 percent), compared with younger GPs aged 25-39 years (70 percent and 41 percent respectively). GPs aged 40-64 years were also less likely to recommend a career in general practice (68 percent compared with 87 percent for younger GPs aged 25-39 years).

Table 7: Attitudinal profile of GP groups by age (n=1,820)

Unweighted base =	All GPs 1,820 %	25-39 412 %	40-64 1248 %	65+ 152 %
% agreeing:*				
• I feel motivated and involved in general practice	78	85	74	82
• I usually have enough time to complete all my daily tasks	36	41	32	53
• I can rely on my colleagues for help and support	81	88	79	85
• I believe I have good work-life balance at present	58	70	53	63
% experienced bullying	11	12	12	7
% experienced discrimination	7	7	7	6
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82	82	82	88
% rating their health positively**	77	72	77	79
% who would recommend a career in general practice^	73	87	68	77

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

There are also significant differences by location, with GPs working in urban locations being slightly less likely than GPs working in rural locations, for example, to state they feel motivated and involved in general practice (78 percent and 81 respectively) (Table 8).

On the other hand, GPs working in rural locations are more likely than GPs working in urban locations, for example, to state they have experienced some form of bullying, harassment or discrimination in the last 12 months (24 percent and 16 percent respectively).

Table 8: Attitudinal profile of GP groups by location (n=1,820)

Unweighted base =	All GPs 1,820 %	Urban 1,352 %	Rural 280 %	Not clearly urban or rural 184 %
% agreeing:*				
• I feel motivated and involved in general practice	78	78	81	75
• I usually have enough time to complete all my daily tasks	36	38	34	34
• I can rely on my colleagues for help and support	81	81	82	83
• I believe I have good work-life balance at present	58	58	57	54
% experienced bullying	11	10	17	11
% experienced discrimination	7	6	8	7
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82	84	76	80
% rating their health positively**	77	76	75	74
% who would recommend a career in general practice^	73	75	74	68

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

There are fewer differences by gender, although male GPs were more likely than female GPs to report having enough time to complete all their daily tasks (40 percent, compared with 33 percent for female GPs) (Table 9).

Female GPs were more likely to rate their health positively than male GPs (80 percent and 75 percent respectively), but they were more likely than male GPs to report they had experienced some form of bullying, discrimination or sexual harassment in the last 12 months (19 percent compared with 15 percent respectively).

Table 9: Attitudinal profile of GP groups by gender (n=1,820)

Unweighted base =	All GPs 1,820 %	Male 770 %	Female 641 %
% agreeing:*			
• I feel motivated and involved in general practice	78	76	79
• I usually have enough time to complete all my daily tasks	36	40	33
• I can rely on my colleagues for help and support	81	79	83
• I believe I have good work-life balance at present	58	56	60
% experienced bullying	11	10	13
% experienced discrimination	7	5	8
% experienced sexual harassment	1	0	1
% reporting none of the above	82	85	81
% rating their health positively**	77	75	80
% who would recommend a career in general practice^	73	74	73

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

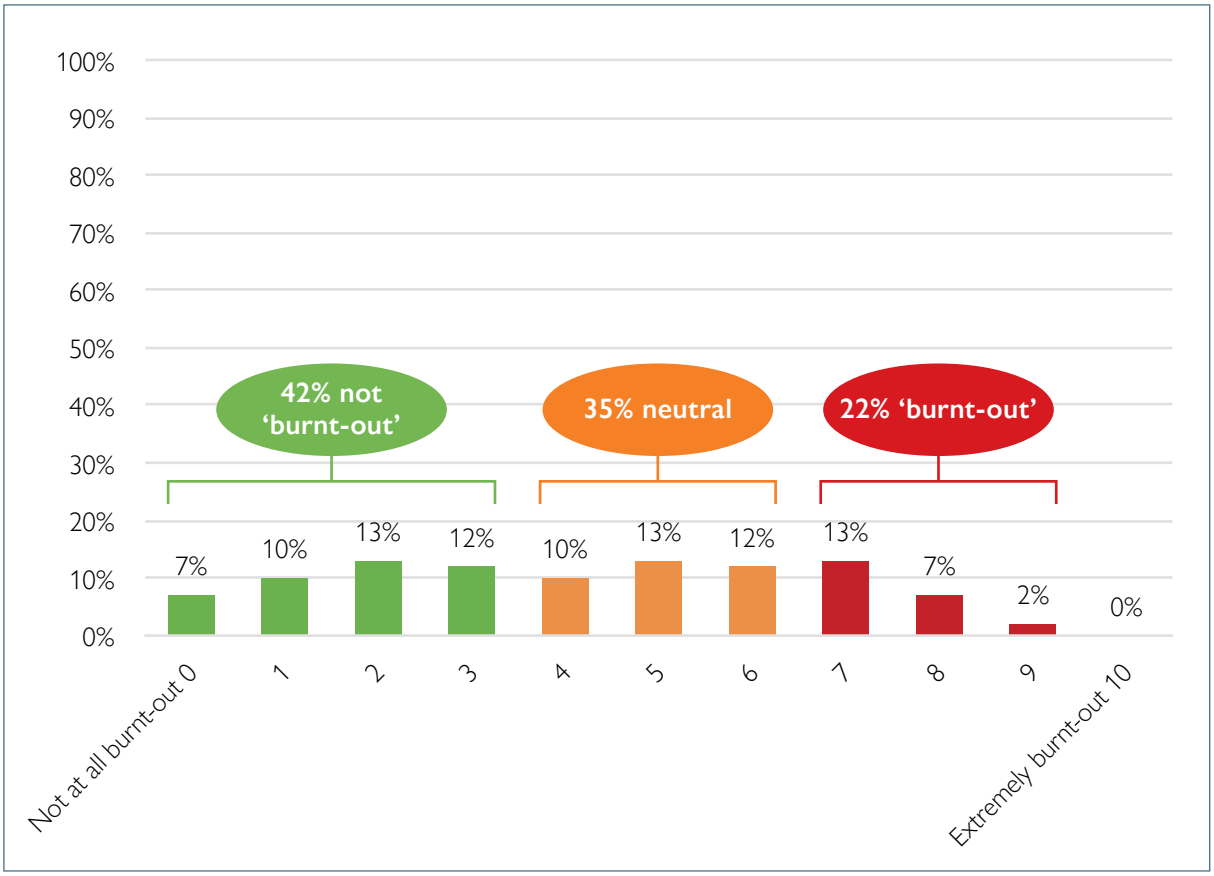
‘BURN-OUT’

One-in-every five GPs feels ‘burnt-out’

Figure 2 shows that 22 percent of GPs rate themselves 7 or above, on a 0-10 point scale measuring self-assessed ‘burn-out’.

Figure 2: Extent to which GPs feel ‘burnt-out’ (n=1,820)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = ‘Not at all burnt-out’ and 10 = ‘Extremely burnt-out’?



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Who is 'burnt-out'?

Table 10 and Figure 3 profile GPs in the three groups reflecting the extent to which they state they are or are not 'burnt-out'. Table 10 shows that, in terms of their work practice, the group of GPs who feel 'burnt-out' are significantly different from the group who state they are not 'burnt-out':

- They are **more likely** to work full-time in general practice (66 percent of those 'burnt-out' work full-time in general practice compared with 42 percent of those who are not 'burnt-out').
- They are **more likely** to have after-hours general practice commitments (71 percent, compared with 62 percent of those who are not 'burnt-out').

Table 10: Working profile of GP groups based on the extent to which GPs report themselves as being 'burnt-out' (n=1,820)

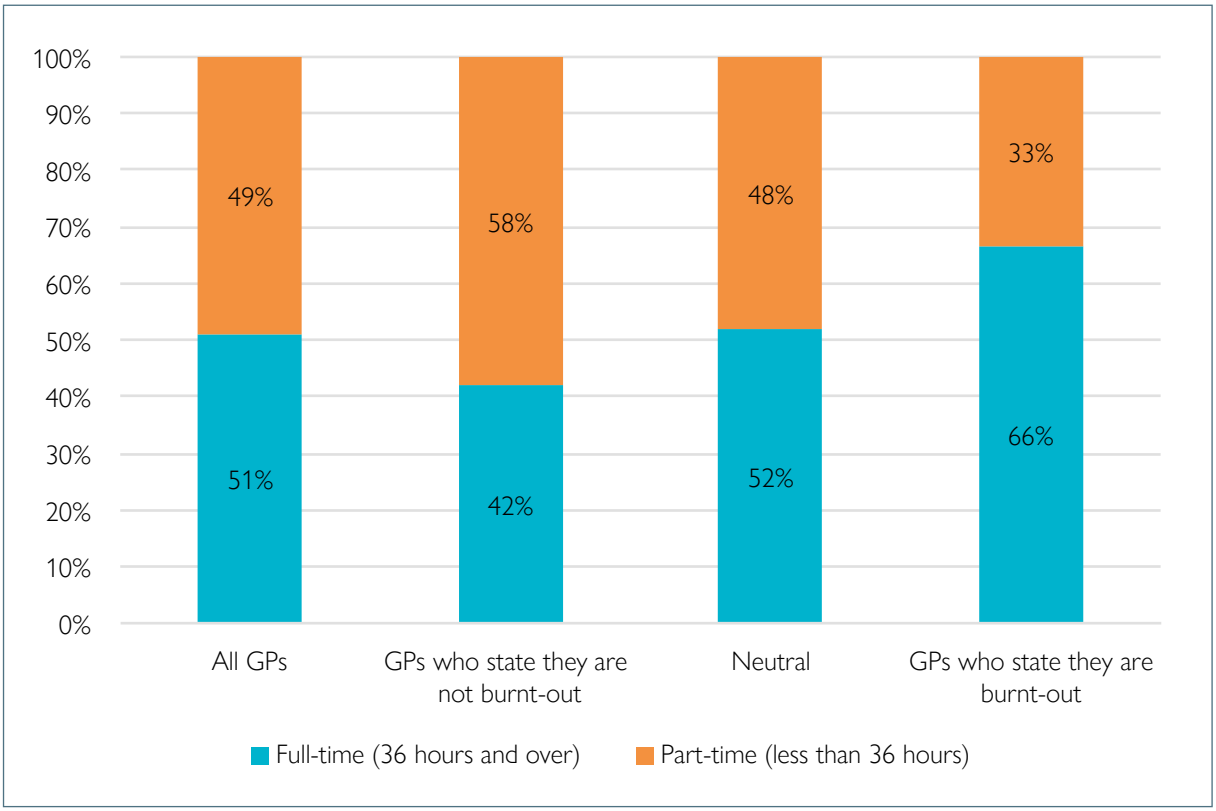
Unweighted base =	All GPs 1,820 %	GPs who state they are not 'burnt-out' 770 %	Neutral 641 %	GPs who state they are 'burnt-out' 409 %
% who spend 26 hours or more per week consulting with patients*	35	29	35	45
% who have 81 or more face-to-face consultations per week*	43	37	40	55
% who spend six or more hours per week on patient-related paperwork*	53	46	55	61
% who have weekly after-hours general practice commitments	66	62	66	71

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

* Based on the mean for all GPs.

Figure 3: Levels of 'burn-out' by full-time/part-time weekly status (n=1,820)



Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

As shown in Tables 11 to 16, GPs who report feeling 'burnt-out' are also **more likely** than GPs who state they are not 'burnt-out' to be:

- Working in general practice on a full-time basis (29 percent of GPs working 36 hours or more in general practice per week, compared with 15 percent of GPs working up to and including 35 hours per week).
- Aged 40-54 years or 55-64 years (25 percent and 26 percent respectively, compared with 16 percent of GPs aged 25-39 years and 15 percent of those aged 65 years and older).
- A practice owner or partner (29 percent, compared with 19 percent of long-term employees and 15 percent of short-term employees).
- Planning to retire within the next five years (30 percent compared with 20 percent of those GPs who are planning to retire in six years' time or more).
- Working in a practice that currently has a vacancy for a full-time-equivalent doctor (27 percent compared with 21 percent of those GPs who had a vacancy in the last 12 months, and 20 percent of those who had not had a vacancy in the last 12 months).

GPs who work in rural general practices, GPs who are registrars, GPs who qualified overseas and GPs who identify as Māori are as likely as other groups to state they are 'burnt-out' or not 'burnt-out'.

Table 11: Levels of 'burn-out' by full-time GPs, by gender (n=924*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Full-time GPs (36 hours or more) 924* %	Male GPs 559 %	Female GPs 355 %
Not 'burnt-out' (0-3)	35	36	33
Neutral (4-6)	36	35	37
'Burnt-out' (7-10)	29	29	30
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked full-time (i.e. 36 hours or more).

Table 12: Levels of 'burn-out' by part-time GPs, by gender (n=893*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Part-time GPs (35 hours or less) 893* %	Male GPs 263 %	Female GPs 620 %
Not 'burnt-out' (0-3)	50	51	50
Neutral (4-6)	35	33	35
'Burnt-out' (7-10)	15	16	15
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those respondents who stated they worked part-time (i.e. 35 hours or less).

Table 13: Levels of 'burn-out' by age (n=1,820)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,820 %	25-39 years 412 %	40-54 years 678 %	55-64 years 570 %	65+ years 152 %
Not 'burnt-out' (0-3)	42	44	39	39	63
Neutral (4-6)	35	39	36	35	22
'Burnt-out' (7-10)	22	16	25	26	15
Total	**100**	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Table 14: Levels of 'burn-out' by whether a practice owner or not (n=1,816*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,816 %	Practice owner/ partner 697 %	Long-term employee/ contractor 837 %	Short-term employee/ contractor (e.g. locum or GP registrar) 258 %
Not 'burnt-out' (0-3)	42	36	44	53
Neutral (4-6)	35	35	36	33
'Burnt-out' (7-10)	22	29	19	15
Total	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

Table 15: Levels of 'burn-out' by those planning to retire within five years and those planning to retire later (n=1,816*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	Total 1,816* %	1 to 5 years from now 413 %	6 years or longer 1,403 %
Not 'burnt-out' (0-3)	42	43	42
Neutral (4-6)	35	27	38
'Burnt-out' (7-10)	22	30	20
Total	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those who provided a response.

Table 16: Levels of 'burn-out' by current GP vacancies (n=1,804*)

Q13 How would you currently rate yourself on a 0 to 10 scale, where 0 = 'Not at all burnt-out' and 10 = 'Extremely burnt-out'?

Unweighted base =	All GPs 1,804* %	Current GP vacancy 517 %	GP vacancy within the past 12 months 680 %	No GP vacancies within the past 12 months 607 %
Not 'burnt-out' (0-3)	42	38	44	43
Neutral (4-6)	35	34	35	36
'Burnt-out' (7-10)	22	27	21	20
Total	**100**	**100**	**100**	**100**

Source: RNZCGP-Workforce Survey, 2016.

Total may not sum to 100% due to rounding.

*Sub-sample based on those who provided a response.

FACTORS ASSOCIATED WITH 'BURN-OUT'

What are the factors associated with being 'burnt-out'?

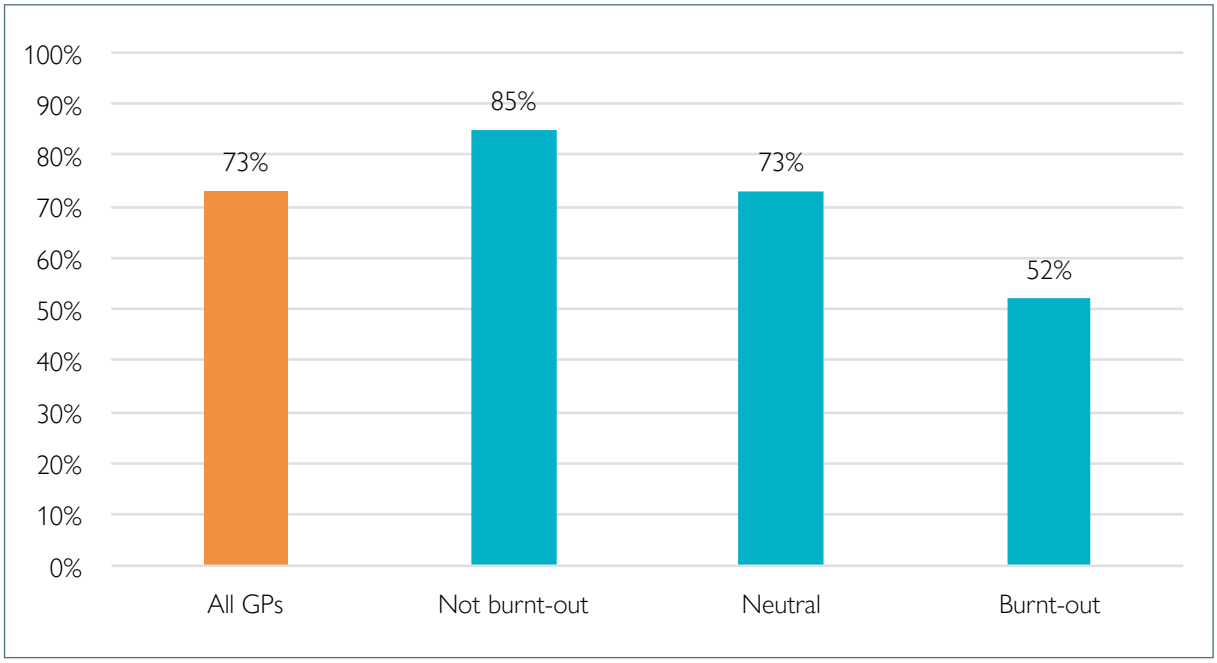
'Burn-out' is also associated with a GP's reported health and general outlook about a career in general practice.

As shown in Table 17, GPs who report feeling 'burnt-out' are generally less likely to respond positively to questions about their motivation, or their health, and to recommend general practice as a career:

- As shown in Figure 4, they are **less likely** to recommend a career in general practice (52 percent, compared with 85 percent of those GPs who state they are not 'burnt-out').

Figure 4: Percentage of GPs likely to recommend a career in general practice by levels of 'burn-out' (n=1,820)

Q10. How likely is it that you would recommend a career in general practice?



Source: RNZCGP-Workforce Survey, 2016.

Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

- A **lower percentage** of those feeling 'burnt-out' state they feel motivated and involved in general practice (57 percent, compared with 88 percent of those GPs who state they are not 'burnt-out').
- A **lower percentage** also state they usually have time to complete all their daily tasks (13 percent, compared with 55 percent of those GPs who state they are not 'burnt-out').
- A **lower percentage** also state they have good work-life balance (23 percent, compared with 81 percent of those GPs who state they are not 'burnt-out').

- A **higher proportion** state they have been bullied (18 percent) and experienced discrimination (11 percent), compared with seven percent and four percent respectively of those GPs who state they are not 'burnt-out'.
- A **lower proportion** rate their health as good or excellent (54 percent, compared with 89 percent of those GPs who state they are not 'burnt-out').

Table 17: Attitudinal profile of GP groups based on the extent to which GPs report themselves 'burnt-out' (n=1,820)

Unweighted base =	All GPs 1,820 %	Not 'burnt-out' 770 %	Neutral 641 %	'Burnt-out' 409 %
% agreeing:*				
• I feel motivated and involved in general practice	78	88	78	57
• I usually have enough time to complete all my daily tasks	36	55	28	13
• I can rely on my colleagues for help and support	81	87	81	72
• I believe I have good work-life balance at present	58	81	53	23
% experienced bullying	11	7	12	18
% experienced discrimination	7	4	6	11
% experienced sexual harassment	1	1	0	1
% reporting none of the above	82			
% rating their health positively**	77	89	75	54
% who would recommend a career in general practice^	73	85	73	52

Source: RNZCGP-Workforce Survey, 2016.

* Percentage of GPs 'strongly agreeing' or 'agreeing' with the statement, based on a 5-point agreement scale.

** Percentage of GPs rating their health with a 4 or 5, based on a 5-point rating scale where 1 = 'poor' and 5 = 'excellent'.

^ Percentage of GPs rating the likelihood of recommending a career in general practice with a 6-10, based on an 11-point rating scale where 0 = 'not at all likely' and 10 = 'extremely likely'.

METHODOLOGY

The 2016 Workforce Survey was conducted in May and June 2016. Research New Zealand, an independent research company, was commissioned to design and conduct the survey, and to analyse and report the results. In this regard, Research New Zealand worked closely with College staff and an advisory group comprising a GP, an Otago University academic and a Health Workforce New Zealand staff member.

In total, 4,686 fellows, members and associates of the College and the Division of Rural Hospital Medicine, received an email invitation with a link to the online survey. A reminder email was sent to those who had not responded one week later. To boost the final participation rate, two more follow-up emails were sent in the subsequent weeks.

The College database, which includes the vast majority of doctors working in New Zealand general practice, was used to identify and contact survey recipients. It should be noted that in New Zealand doctors are legally able to work in general practice without the additional training required for vocational (specialist) registration, and these non-vocationally registered doctors are not usually included in the College database.

A total of 2,087 valid responses were received by the survey close-off date, giving a response rate of 44.5 percent. This included eight incomplete responses which were included in the analysis, given that the answers to only a small number of the survey questions were missing.

Approximately 100 respondents stated they had only worked in rural hospital medicine and these respondents were excluded from the analysis. Additionally, some respondents were doctors that were not part of the current workforce (e.g. they were retired or were working overseas). These respondents were also excluded from the analysis. As a result, unless otherwise specified, the data and analysis in this report is based on the responses to the survey questions for 1,820 respondents who stated they had worked in general practice in New Zealand in the three months prior to the survey.

A comparison of the age and gender profile of survey respondents to the age and gender profile of those on the College database was also undertaken. As this showed a close match between the two profiles, the survey data has not been weighted to correct for any variations.

Therefore, all data in this report is presented on an unweighted basis. Not all questions were compulsory and the survey was structured so that respondents were not asked questions that were not relevant to them. Therefore, the totals in the tables differ according to the number of doctors who responded to the relevant question.

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