ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Joan

Development of a new collegial peer support and supervision framework for International Medical Graduates

Thank you for the opportunity to provide feedback on Council's proposed framework for collegial peer support and supervision for International Medical Graduates (IMGs) (the Framework), and the Orientation, Induction and Supervision Guide (the Guide).

Toi Mata Hauora, the Association of Salaried Medical Specialists (ASMS) is the union and professional association of salaried senior doctors and dentists. We were formed in April 1989 to advocate and promote the industrial and professional interests of our members, most of whom are employed by Te Whatu Ora Health New Zealand as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. We have over 6000 members.

1. Do you support the proposal for a framework that allows an IMG to either undertake a period of collegial peer support or supervision, depending on the registration pathway?

The induction, orientation and support (including collegial and/or supervisory support) that IMGs receive is fundamental to their transition to employment and practice in the Aotearoa New Zealand health system, and important to fostering their sense of belonging. ASMS understands the purpose of orientation, induction and supervision to integrate safely into the health system in Aotearoa New Zealand and assess an IMG's performance against the expected standard of medical practice. The proposal does not appear to strengthen how these aims are embedded into the peer support and supervision framework.

The ASMS has concerns regarding the proposal's feasibility, with a view to the severe limits on SMO capacity and ever-increasing workloads in the face of entrenched staffing shortages. An implicit rationale for the proposal – to codify what is likely already common practice for supervision – in many places runs contrary to what is stated in the Guide.

For this reason, it is difficult to form a position on whether or not ASMS supports the proposal, as it is unclear what a re-draft of the Guide would look like.

The proposal states the framework "determines whether an IMG will undertake an initial period of peer support or supervision, based on registration pathway. We see that it would be more accurate to say that this would be based on "key criteria that inform" the registration pathway, rather than the registration pathway itself.

The key criteria differentiates between IMGs assessed as "equivalent to" and those assessed "as satisfactory as". The former allows for a horizontal and peer-based collegial relationship, while the latter aligns with the existing vertical supervisory structure.

We are concerned that the proposal places additional responsibility on Chief Medical Officer (CMO), Clinical Director (CD) of the Primary Care Organisation or Clinical Lead (CL) of the general practice. These roles have significant responsibilities with little additional time or resource.

The proposed Framework may be intended to enable improved utilisation of existing SMO capacity to support supervision requirements, but SMOs continue to experience chronic workforce shortages, which manifest as entrenched vacancies, inability to recruit, missing colleagues and excessive workloads. Our recent survey of Clinical Directors found that just 35 per cent of respondents stated that they were able to dedicate the necessary time to supervision within their departments[1].

2. Do you see any potential adverse consequences, and if so, how can they be mitigated?

The concerns we have outlined below are attributable in part to the chronic shortages of SMOs in the public hospital system and primary care, as well as the level of detail contained in the proposal.

We also see risk in the departure from best practice as established by the Guide. While we see the need to modernise and review the Guide for currency, the lack of any references to the Guide in the proposal makes it difficult to know to what extent the information will remain the same if the proposal were to be implemented, for example:

- Whether or not the supervisor must be vocationally registered in the same scope of practice (p27)
- Whether or not an additional supervisor is required (p28)
- If the definitions of formal and informal supervision apply (p37)
- Information on supervisor's responsibilities (p42)
- If the approved practice setting requirements apply (p52)

Induction and orientation processes

Our industrial team reports that induction and orientation remains inconsistent and highly variable across Aotearoa New Zealand. This is further underscored by our research which finds just 3.1% of

[1] ASMS. Staffing survey of Clinical Directors. June 2025. Forthcoming.

IMGs surveyed saying they received any information on the New Zealand health system, and almost half (49.1%) stating they did not receive any formal induction at their place of work[2].

While we are supportive of induction plans being reported to Council as part of the quarterly reporting for both pathways, Council should consider developing a principles-based induction framework alongside the Guide in order to ensure its expectations for induction, orientation and supervision are well understood and applied consistently.

It is also important to ensure doctors receive appropriate cultural competence and cultural safety training, as well as an introduction to Te Tiriti o Waitangi and hauora Māori as part of their orientation to practice in Aotearoa. A clinical peer and/or supervisor should not be expected to provide this aspect of an IMG's induction. Results from our IMG survey found that only one in four IMGs received any training in cultural competency training upon arrival in Aotearoa. We recommend that Council includes explicit guidance to employers to provide cultural competence, cultural safety and Hauora Māori training as part of orientation and induction.

Collegial peer support

The proposal states that the Chief Medical Officer (CMO), Clinical Director (CD) of the Primary Care Organisation or Clinical Lead (CL) of the general practice will be responsible for the IMG, but the day-to-day support can be delegated to a named peer, including signing off quarterly reports. The balance of responsibility and delegation will have to be managed by the CMO, CD or CL, and we suggest Council include a recommendation that the nominated peer maintain lines of communication with the CMO, CD or CL given these roles retain ultimate responsibility for the IMG. The proposal does not include a requirement for CMOs to sight or sign off on quarterly reports in addition to the peer.

The Guide states that supervisors must be the same vocational scope as the IMG, but the proposal allows collegial peers to be from "the same or similar area of medicine" – a departure from the requirements in the Guide.

There does not appear to be a requirement for the nominated peer to be present in the same department or work site as the IMG. We recognise that having the CMO, CD or CL at the same work site may be impractical, especially in the case of general practices within a Primary Health Organisation (PHO) network or larger metropolitan hospitals with multiple large campuses; however, if the intention is for day-to-day support, this is best carried out by someone based at the same site, rather than a peer only available remotely. Given the shortages of SMOs, especially in smaller subspecialties, rural areas and general practice, ASMS sees a risk that IMGs may not get in-person peer support. This poses a risk to the stated aims of supervision: safe and competent integration into practice in Aotearoa New Zealand.

The peer support pathway does not include a mechanism in the case of a relationship breakdown between and IMG and peer, as is detailed in the supervision pathway.

We also encourage the Framework to be explicit in supporting the development of collegial peer relationships between an IMG on this pathway and their nominated peer. The proposal provides little detail around how an IMG might practically be supported beyond the examples of multidisciplinary

[2] ASMS. The future intentions and experiences of International Medical Graduates in Aotearoa New Zealand. Forthcoming.

team meetings and peer review, which ASMS sees as standard components of good clinical supervision, rather than mechanisms designed specifically to support IMGs.

Supervision

The Supervision pathway will be available to IMGs assessed as satisfactory as a New Zealand-trained specialist on the provisional vocational pathway; registered in a provisional general scope of practice; or registered in a special purpose scope of practice.

The current Induction guidelines state that "registration will not be approved for IMGs applying for registration in a provisional vocational scope, where they must be assessed for 12-18 months, and where off-site supervision is proposed". The relaxation of this requirement under the current proposal appears to be responding to external pressures, rather than emphasis on patient safety and practitioner competence.

ASMS is particularly concerned with the proposed minimum two-week period of on-site supervision. This is a significant change from current practice, which recommends at least two to four weeks. While the document notes that on-site supervision may be extended to three months, it is unclear how a need for an extended period of on-site supervision over and above two weeks would be determined. When lower timeframes are introduced, this tends to become the accepted standard rather than an established minimum. Further, a two-week minimum will likely impact resourcing: given the strain existing SMO capacity continues to experience, it is highly unlikely that addition SMO time to provide supervision will be available in excess of the two-week minimum.

The parameters of the proposal are vague. While we recognise this will be intended to provide flexibility and the ability to adapt to different circumstances, the absence of recommendations for the mandatory components within the supervision pathway (numbers of difficult case discussions, direct observation of procedures etc.) makes it difficult for time-poor supervisors and IMGs to know what will meet Council expectations. This was difficult without the proposed updates to the Guide to read alongside the Framework.

Implications for employment contracts

The ASMS Collective Agreement recognises that "the date an employee met the requirements for vocational registration (or its overseas equivalent) will be used to assess when an employee would have been first placed on the specialist scale (not the date when the employee was vocationally registered)."

Doctors granted provisional vocational registration are eligible for placement on the specialist scale. This is irrespective of whether they are on the VOC3 or VOC4 pathway. Our Industrial Officers have examples where IMGs who have been assessed "as satisfactory as" a New Zealand trained specialist have been offered a step placement on the medical officer scale that does not reflect their skills, qualifications or experience. We see a risk that the supervision pathway will be used as justification to refuse initial placement on the specialist scale to employees, until vocational registration is obtained.

3. Do you have any other comments regarding the proposed framework?

A comment on language

Both proposed pathways use the word "include" before listing a series of bullet points ("key elements under the proposed framework include"). This suggests that the list is not exhaustive, and there are aspects of the Framework that are not listed. The final document should state all aspects of the Framework clearly and completely.

Induction, Orientation and Supervision Best Practice Guide

Having a copy of Council's proposed changes to this document (as tracked changes in a PDF or draft document) would have been helpful in developing our feedback and provided greater insight into how Council sees the proposal working in practice.

The current Orientation, Induction and Supervision Guide document uses language that could be construed as reinforcing deficit approaches to some groups – Māori and women, for example.

The Guide does not mention Unions. ASMS regularly provides advice to IMGs looking to relocate to Aotearoa New Zealand, and some Te Whatu Ora Districts will also encourage prospective employees to make contact with ASMS regarding advice and review of job offers. Inclusion of unions as a source of advice for IMGs on their employment would reflect current practice.

Thank you for the opportunity to provide feedback on Council's proposal. To discuss our feedback further, please contact Harriet Wild, Director of Policy and Research, at hw@asms.nz.

Nāku noa, nā

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