Chocolates anyone?

By Andrew Old, Chair, NZMA Doctors-in-Training Council

In the words of Forrest Gump, "life is like a box of chocolates - you never know what you're going to get". Sadly, if you compare recent medical workforce reports to chocolates, and I think that you can, then they've all been marshmallow caramels. A little bit fluffy, sometimes a bit chewy, and largely passed over. Frankly, I'm tired of marshmallow caramels. As the world holds its breath (or not) in anticipation of the first Health Workforce Taskforce report, I can't help but think that what we really need is a big chilli chocolate bombe! A chocolate that makes people sit up, take notice, and forces action (even if that action is only to find a glass of water to dampen down the heat). Whether there is any heat in the upcoming report remains to be seen, but a cynic would have good reason to doubt, when the recommendations of both the Medical Reference Group (of the now defunct Health Workforce Advisory Committee) and the Doctors-in-Training Workforce Roundtable have had such little impact on the way we train and employ doctors.

Of course it's not simply enough for the Taskforce to add a whole lot of spice to the mix. This chocolate needs to have depth, complexity and, most importantly, a long lasting and pleasant after-taste.

If I was the chocolatier then, what would I put into the mix? Well, for starters, I'd want to make sure that there was a market for my chocolates! That is, what 'problem' exactly are we trying to address? One of the NZMA Doctors-in-Training Council's early concerns with the Taskforce was the Minister's direction to focus primarily on 'streamlining' education and training without necessarily consideration of the 'why'. Is it an economic problem, i.e. do we want to train our doctors for less money, or do we want to spend less on providing the service that doctors currently provide? Is it about quality and safety, i.e. do we believe that changes will improve the quality of our graduates? Or is it to lock our graduates into a system that will discourage them from going overseas? Or is it something else entirely? If we can't clearly articulate what it is we are trying to achieve, then it is extremely unlikely that any changes will result in the desired outcomes.

Secondly, and inextricably linked to the first, I'd ask myself "what do we want doctors to do?" Put another way, "where do we (or should we) fit into the system?" To extend the chocolate analogy now to doctors themselves, do we need generalists, a glorious homogeneity of chocolate filling with a touch of spice for variation? Or super-specialists, great when you've got what you want, but you can't make a crème de menthe out of a strawberry fondant? New Zealand's demography demands generalism. Generally trained doctors will always be more flexible and responsive to the health needs of society than people who are trained specifically for certain tasks or areas. Coupled with this, the debate around early streaming, which was another way of 'streamlining' the Taskforce was asked to look at, is similarly fraught with difficulty. Put simply, something's gotta give. If you provide

more specialist content earlier, then you either have to reduce the generalist content or have longer teaching years. Narrowly qualified graduates will not be able to do all the things that we currently expect our graduate doctors to do. Do we really want a system where the orthopaedic surgeon of the future needs to refer to a renal physician every time a post op patient develops a UTI? And what happens when a renal physician isn't available? In Westport…? On a Sunday…?

Complicating the situation is the fact that some cooks are missing from the kitchen. Given that the Taskforce has deemed trainee representation unnecessary, one wonders how the Taskforce is going to effect any meaningful change without the close collaboration of the doctors-in-training they hope to affect. Beyond failing to develop relationships, one wonders about the quality of information if the subject members are ignored. Junior doctors are highly intelligent, articulate and motivated. Whilst the Taskforce presumably worry about our ability to see the big picture, lack of representation risks missing our motivations, observations and on-the-ground experience that are essential to making it (whatever 'it' is) work. Of note, there seems to be no drive from trainee groups to speed their training, and the NZRDA has consistently been championing lifestyle balance as important in negotiations with employers. If doctors are in no hurry to take on the heavy burden that is consultant-hood, 'smoothing the path' will make little difference if RMOs are happy to keep on keeping on at our own pace.

Enveloping all of this, are the continuing concerns around recruitment and retention of our medical workforce, protecting the apprenticeship model of training and our professional unity, and ultimately ensuring ongoing quality care for the public of New Zealand. It's a complex recipe.

So, what would the DITC like to see in the Taskforce report? Most importantly, the document needs to clearly articulate the issues with the status quo, the role of the doctor, and how that role might need to change to address the identified issues. Any solutions need to effectively walk the tight-rope between current service delivery and training needs, and identify flow-on effects to future health care delivery and the shape of the future workforce.

The Taskforce is due to report to the Minister on 31 March and we can but wait, see and hope for what recipe they'll decide to use. Chocolates anyone?