

DiTC Annual Trainee's Forum Summary of Proceedings Saturday 27 August 2011

Attendees

Dr Jonathan Foo (Chair DiTC), Dr Emily Gill (Deputy Chair DiTC), Dr Justin Beardsley (RACP), Dr Rob Bevan (CICM), Dr Joanne Glengarry (RCPA), Dr Bronwyn Morris (NZCPHM), Dr John Langham (RNZCGP), Dr Jeremy Webber (RNZCGP), Dr Sheila Hart (ANZCA), Dr Rachel Dempsey (ANZCA), Dr Kristin Chard (RANZCR), Dr Matt Boyle (RACS), Dr Leigh Searle (RANZCOG), Dr Nav Sidhu (NZSA), Dr Dilky Rasiah (RACMA), Dr Kenneth Chan (RANZCO), Dr Paul Ockelford (NZMA Chair), Dr James Blackett (DiTC), Dr Jesse Gale (DiTC), Dr Ciaran Thrush (DiTC), Dr Anna Choi (DiTC), Mr Oliver Hansby (NZMSA President), Mr Michael Chen-Xu (NZMSA), Ms Lesley Clarke (NZMA CEO), Ms Lucille Curtis (NZMA Senior Policy Advisor).

Guests

Dr John Adams, Chair Medical Council of New Zealand (MCNZ) (from 11am – 3pm)
Prof. Des Gorman, Chair Health Workforce New Zealand (HWNZ) (from 1pm – 3pm)

Political and advocacy

Dr Ockelford, New Zealand Medical Association (NZMA) Chair, gave an update on current issues and the role of the NZMA.

He said that a major focus for the NZMA over many years has been on workforce and while previous governments have preferred to ignore the issue, the current government has taken it on and has made a significant investment in workforce through HWNZ. In respect of this we have seen an increase in medical school intake, an increase in GP training positions, and the creation of the Voluntary Bonding Scheme and the Advanced Training Scheme. There has also been a move to medical career planning. In regard to the latter the NZMA is very aware of the problems that have arisen in respect of implementation (particularly at Middlemore Hospital) and we have been speaking to HWNZ about our concerns.

While we may not agree with everything HWNZ is doing, at least the new entity gives us the opportunity to have our input. What is now becoming evident is that HWNZ is not communicating sufficiently with those involved in or affected by the changes.

Dr Ockelford said that the NZMA has also met with the MCNZ on prevocational training requirements in New Zealand. While we strongly supported the objectives of the review we were particularly concerned about the variable quality of training. We were also critical of the proposed time based extension of run allocations and have raised this as an issue with the MCNZ.

Dr John Adams, Chair of the Medical Council of New Zealand

Dr Adams spoke about the MCNZ's consultation on provisional registration. He said that one of the major drivers for the proposed changes was the number of reports there had been on workforce, and the concerns raised about the house surgeon years. This was most recently raised in the Resident Medical Officer (RMO) commission report.

To date the MCNZ had run nine meetings around the country and received a number of submissions. One of the themes from the feedback is that the proposal has focused on

structure rather than quality. Dr Adams acknowledged that quality was also extremely important to the Council, however, the Council felt that it needed to put something out about structure.

In preparing the proposal the MCNZ focused on the outcomes they wanted i.e. to have a doctor who met the competencies required to practise safely under a general scope of practise in the New Zealand environment.

Dr Adams advised that some of the options put up might not be workable e.g. including extra mandatory runs in general practice, and accident and emergency, may be unfeasible given the resources available. Some of the feedback so far has suggested that the MCNZ should not try to implement everything at once. Instead it should work to a vision.

Dr Adams advised that there was little consensus about most of the things he has talked about so far. There was a wide disparity of views and the opposing views were often equally compelling. The major arguments centred around mandatory runs and the length of attachment; whether provisional registration should be one or two years.

Dr Adams then talked about student registration. He said that initially the Council had thought that there should be student registration from the second year on however, as discussions have progressed, it has become clear that the things the Council was trying to fix related to the Trainee Intern (TI) year. He said that the Council also needed to have more discussion with the colleges – in particular, could there be some way that colleges could have some oversight during PGY2?

Questions

Q Isn't it impossible to get a doctor fit for practise after provisional registration as there will always be areas of medicine that they would not be competent to practice in?

A Dr Adams said that, as a regulator, the Council did need to set a minimum standard. While being able to practice with general registration is an issue, the MCNZ was unlikely to desist with general registration anytime soon. There are currently a large number of general registrants in practice in New Zealand. He said that the MCNZ has sent out a RFP for a CPD programme for general registrants. It is hoped that soon everyone who is generally registered will have to be part of an ongoing CPD programme. Part of this will mean an increase in supervision and CPD requirements.

Q Does the MCNZ want people moving quickly into vocational training or do they value time in general training or both?

A Dr Adams advised that this was problematic because there are some people who choose to stay in general registration. Dr Adams indicated that New Zealand did not have the resources to be able to go down the sub-specialist path.

Q If a check list of competencies was likely to be developed, it was possible that a trainee can go through all of these and, at end of it, still be no safer. Comments?

A Dr Adams said that there was a critical interface between the colleges and the councils. He said that the MCNZ wanted to see the colleges develop a system to identify people who are

performing poorly and working with them before the matter was sent through to Council as once this happened it would then be dealt with in a quasi judicial process.

Q The trainees asked Dr Adams to provide an update on the scope of practice for trainee interns and the proposal to give them limited prescribing rights.

A Dr Adams said that the matter still needs further discussion. In order to do this the Council needed to develop a scope of practice for trainee interns to be able to do this. The medical schools are very supportive of the proposal. By instituting limited prescribing this will give the trainee more responsibility and therefore more learning opportunities.

Professor Des Gorman, Chair of Health Workforce New Zealand

The session began with Prof Gorman being introduced to each trainee and talking to them about their specialty. From this discussion Prof Gorman made the following general comments:

- HWNZ will be providing funding for the third age career. They did not want doctors to have to retire at 65. He was not certain at this point what a third age career might look like.
- Prof Gorman was very supportive of dual training. He saw this as the right thing to do and allowed the doctor the ability to retrain him/herself.
- There won't be a single funding model adopted in NZ. Rather the National Health Board (NHB) will use different models for different places and for different models of care. There will no longer be any reliance on fees for service or capitation.

Questions

Q HWNZ's Investment Plan. There were a number of assumptions made in respect of service versus training. Where did HWNZ get these figures?

A Prof Gorman advised that the figures were a best guess and that HWNZ is likely to continue working on them until HWNZ achieves a sensible fit. He said that next year HWNZ will be working on a scorecard for health workforce planning and performance for key DHB accountabilities. A finite amount of money will be given to DHBs for training. At the moment HWNZ is trying to determine what the best value for that blend is.

Q Is there a risk that if HWNZ diverts money to areas of need it will negatively impact on other areas?

A Prof Gorman concurred that there was a risk. The history of health workforce planning was a history of repeated failure. We had fallen into the trap of long term funding commitments which did not account for how quickly needs in the health workforce changed. HWNZ's plans need to be able to change to meet this.

Q The question of making rural places attractive to trainees was raised. Did HWNZ want to make these places attractive or would HWNZ simply force trainees to go to them?

A Prof Gorman said that in the first instance they would try to make working in rural areas more attractive however, ultimately there may be a level of coercion. Treasury's view is that given the amount of money the government spends on medical students it is reckless not to bond them.

Q The proposal is for four training hubs. How much will people be locked into a particular hub?

A Prof Gorman's view of the hubs is that they will have a core set of expectations but beyond that he expected them to have their own flavour and that the hubs would be competing between them for trainees.

Q Would Prof Gorman comment on the physician assistant trial?

A Prof Gorman said that the trial was a success. There was high acceptance of it by surgeons although he noted that it was not a model that will be adopted across the country. HWNZ is going to be doing a number of further trials. There is a large trial currently being set in primary care. HWNZ is looking closely at how to fund managed care, and practice extenders are being considered carefully.

Panel discussion with Professor Gorman, Dr Adams and Dr Ockelford

Following the discussion with Prof Gorman the three speakers came together as a panel to discuss wider issues.

Questions

Q Communication: How can we improve getting the word out to the frontline? The feedback we receive is that HWNZ is not communicating. The reality however, is that HWNZ is always trying to communicate but collating and disseminating is problematic.

Prof Gorman agreed that HWNZ had a major communication problem. Some communication can only be in a small collegial group like this one, but there are real problems communicating with 135,000 health workers. HWNZ keeps looking to find new vehicles for communication.

Dr Adams agreed that communication was a huge problem. He suspected that people are getting buried in so much communication that it is difficult to pick out what is important from all the rest, and of course people are really busy in their own jobs.

Q Would there be a role for the MCNZ to make leadership a CPD requirement?

Dr Adams said that this was more of a college responsibility than MCNZ's. Prof Gorman said that he saw a need for a footprint in the medical schools for leadership and professionalism. It might be, however, that we need to be more strategic about how to communicate. There is a structural problem with the profession in that it is very splintered.

Prof Gorman closed the panel discussion by requesting feedback from the group. While he was happy to return to the forum next year he wanted to hear back from the trainees in regard to some of the questions asked. He said that he was particularly keen to hear how the trainees wanted HWNZ to communicate with them.

Discussion of College issues by trainees

The college trainee representatives then gave a brief synopsis of the issues facing their colleges. Key issues discussed included:

- curriculum changes (ANZCA, RNZCGP, RANZCR, NZCPHM)
- funding problems (CICM, NZCRHM, funding “boom” RACMA)
- problems in getting training positions in New Zealand (RCPA)
- increasing service demands due to health targets and/or new treatments (RANZCR, RANZCO)
- impact on Regional Hubs (RACMA – problematic, RANZCOG – unconcerned)
- training (RACS, RACP).

Where to from here and wrap up

Communication

One of the trainee representatives said that she was concerned because most of the communication trainees receive is from the Resident Doctors Association (RDA) and they provide a very skewed view of what HWNZ says. Other trainees complained that if HWNZ was sending information out affecting trainees it wasn't passed on through the college.

It was felt that it would be good to have a web based forum or conduit where all the trainee representatives can engage. They could then field the issues and update the trainees in their college.

It was decided that for the next year the NZMA DiTC should use the emails from this trainee forum group to feed through ideas. **Action point**

The meeting closed at 4.15pm.