



Medical Education and Training Position Statement 2009

Background

The Medical Training Board (MTB) was created in 2007 on the recommendation of the Workforce Taskforce, after broad agreement that there was a serious shortage of doctors in New Zealand, and a need to better coordinate workforce with education and training. In its first year the MTB focused on two tasks;

- 1) determining the needs of the future workforce, and
- 2) analysing the curriculum framework.

Firstly, the MTB performed a comprehensive analysis of workforce projection and recommended that funded medical student places be increased by 100 in the first instance. The incoming National government decided in December 2008 to increase medical student places by 200 by 2012.

Secondly, the Workforce Taskforce, and now the MTB, also considered the curriculum framework for medical training (from medical school through to specialist training). It is recognized that the framework determines the number and type of doctors that are created, and also influences how doctors-in-training work, which both affect healthcare delivery in New Zealand. There are a number of potentially positive and negative proposals for medical training under consideration.

This position statement therefore considers the issue of medical education and training.

Position Statement

a) Philosophy driving MET

i) Role of the doctor

There must be a clearly defined notion of the role of the doctor, both in present-day and future terms. This is particularly important given the continued creation of new roles in health.¹

ii) Educational theory and the apprenticeship model

Many methods of medical education and training have a historical, rather than evidence-based, foundation. The development of medical education as a discipline, and the application of broader educational evidence to medical training, has seen

¹ For further information see the NZMA position statement on “*The Changing Nature of the Medical Workforce; New Roles and Role Substitution*”

some changes to traditional medical teaching practice. Notwithstanding this, medical education has long been grounded in the apprenticeship model of learning, whereby doctors in training gain knowledge and skills from their superiors as they work together. In recent times, medical educationalists have commented on the erosion of this relationship for a variety of (primarily service-based) reasons.

The NZMA encourages the use of sound educational theory in the development and refinement of medical education. The NZMA believes that the apprenticeship model of teaching and learning is vital to the success of medical training because of the highly practical nature of medicine, and that efforts should be made to preserve it.

iii) Lifelong learning

Good medical practice involves continued learning and education over the course of practitioners' careers- not just in the 'training' years.

The NZMA supports initiatives that foster this commitment to lifelong learning.

b) Service/training balance

Doctors in training are employed to provide a service. The work environment is, however, also a training environment in that it is where interactions with senior colleagues take place, and also where patients are examined and new skills are taught and mastered. As workforce shortages create increasing service demands, doctors-in-training find themselves unable to gain new knowledge and skills from their experiences as supervision and time pressures are both stretched. The balance between service and training demands in the workplace is generally skewed because in public hospitals - the primary work place for doctors in training - service demands are always high. Consequently, formal training is seen as an 'optional extra' that frequently gets sidelined. However, the ongoing education of doctors by doctors is at the core of medical practice.

The NZMA also recognizes that some types of medical education and training require commitment outside the work environment - for example, private study, clinical simulation, and course and conference attendance. Whilst some of this will be done in accordance with doctors' commitments to lifelong learning, we encourage employers to recognize the value that these activities add to their employees' practice and to support medical education and training of all types.

The NZMA believes that:

- *DHBs must become involved in and clearly accountable for training and must provide resources for medical education at all levels.*
- *Dedicated training time must be made available to all doctors in DHBs.*
- *Teaching skills need to be taught and funding should be put in place to support this.*

- *Workplace teaching should involve both formally structured sessions and opportunistic bedside/ward teaching (the provision of which is usually based on adequate medical staffing).*
- *The Clinical Training Agency needs strong governance from a body with good knowledge of medical education and training, in order to ensure that it funds quality and appropriate programmes. The Medical Training Board could potentially provide that oversight, if its current structure is maintained.*

c) Structure of Medical Education and Training

i) Duration of Medical School

Among other matters, the Workforce Taskforce was asked to consider,

- 1) shortening the undergraduate degree,
- 2) early specialization, possibly at undergraduate level,
- 3) collapsing the first two postgraduate years (PGY) into one, and
- 4) recognition of prior learning.

At the end of 2006 NZMA wrote a submission to the Workforce Taskforce, rejecting the first three options on the likelihood of lower quality graduates and false economy. Recognition of prior learning might be a positive option for some students.

Since that submission Professor John Campbell, chairman of the Medical Council of New Zealand, has suggested a move from a 6 year undergraduate degree with 1 year provisional registration, to a 5 year degree with 2 year provisional registration. There are a number of considerations which relate to this proposal, central of which is the issue of quality. In addition, the NZMA cautions that:

- The five-plus-two model does not address workforce shortages as it simply creates one year group of double graduates, which would require significant planning.
- Any change to the undergraduate medical course may alter the relationship of reciprocal registration that we currently enjoy with Australia. This relationship is currently managed by the Australian Medical Council Accreditation Committee. Issues of equity, necessity and workforce impact would need to be balanced with any proposed benefit of this arrangement so as to avoid undermining this arrangement.
- The trainee intern year is a valuable and unique component of New Zealand medical training, and should be retained. Important educational experiences which are undertaken in the trainee intern year should be retained in any shortened undergraduate course. This would include both a period of clinical clerkship and the option for an extended "elective" to increase breadth and depth, after completion of final examinations.

- The quality of training for PGY1 and 2 doctors varies considerably between DHBs and departments. The key to a five plus two model is in ensuring consistency and quality of training in the two years of provisional registration.
- There are limits to what Medical Council regulation can achieve in ensuring good educational content in these provisional registrant jobs. Ensuring good training will require both funding and motivation for DHBs to create appropriate positions for provisional registrants.
- The five-plus-two model would create twice as many provisional registrants, requiring support and supervision from senior medical officers as intern supervisors.
- The total length of training should not be extended.

The NZMA considers that a proposed change to a 'five plus two' structure (five years medical school with two years registration in a general scope of practice) is potentially feasible, subject to the caveats noted above.

ii) Graduate entry and Graduate Medical Schools

Graduate students entering medical training have a lot to offer the medical profession in that they often bring broader life experiences. The NZMA notes however, that in undertaking a degree prior to medicine there is inevitably a cost escalation in the total training of the doctor.

Graduate entry medical schools are operating in Australia and offer a shorter (four-year) course solely for graduates of other degrees. These schools allow graduate students to become doctors one year faster than the current model. They should not be seen as a quicker or cheaper way to train doctors, as each new doctor spends at least seven years in undergraduate training. Therefore they do not have any benefits over the conventional shared courses we currently have, and are more expensive overall. If a third medical school in New Zealand were proposed, based on graduate entry, then significant curriculum development would be required.

The NZMA would only support a new graduate entry medical school in New Zealand if it could be shown to maintain our current high quality training standards, and represented reasonable value for New Zealand's overall medical training expenditure.

iii) Training in alternative settings

An adequately resourced public hospital system provides a rich and diverse learning experience for medical students and doctors in training. The NZMA believes that this environment should be further developed and strengthened over time, and that greater utilisation should be made of the generalist environments offered by peripheral and rural hospitals.

NZMA believes that there needs to be consideration of training in settings other than public hospitals because:

- there has been a shift toward acute problems and shorter stays in our public hospitals, so that doctors in training have less exposure to some conditions managed in community and private care. This has led to concern that graduates are not fit for purpose.
- many procedures and operations are no longer being done or are not done in the Public Hospital system due to funding, ACC contracts or other issues. This necessarily limits doctors in training' – and particularly those studying to be surgeons' - exposure to procedural skills.
- it is likely that the public hospital system will have difficulty in accommodating the increased number of trainees set to increase substantially.

Private hospitals are a largely untapped training resource. The experience of general practice training shows that the private sector can play a very valuable role in medical training. Indeed, recent evidence from the Otago rural immersion scheme for 5th year students shows that Primary Care facilities are not only a valuable resource but may provide better training than is the case in the public hospitals.

Any training planned for new settings will need to be subject to the following principles:

- Training positions must be accredited by the relevant accrediting authority to ensure that the high quality of training is maintained. Independence between employment and educational supervision should be aimed for where possible, and where conflict between these roles is inevitable guidelines should be developed to protect doctors in training.
- Private practices must be resourced appropriately to take on a training role. Resources should be provided by government and should be focussed on infrastructure, educational resources, support for the acquisition of teaching skills, IT resources, human resource management support and the like. Private practices must meet minimum requirements for supervision.
- The system for training in the private sector must ensure that income generated by the activity of the doctor in training together with government or other subsidies fully compensates the practice for losses incurred by taking on a training role.
- There must not be any reduction in services at public hospitals as a result of doctors in training moving into the private sector - Public teaching hospitals should continue to play the central role in training and should be appropriately resourced.
- Arrangements for training in private settings must respect patient choice by ensuring that all patients treated by doctors in training are informed about the role of trainees in their medical care and freely consent to this.

- Entitlements and working conditions for doctors in training must be protected - doctors in training must not be disadvantaged either financially or in terms of working conditions (including patient safety).
- Medical indemnity arrangements must not disadvantage or impose extra costs on medical students, doctors in training or their supervisors.
- There must be professional support for supervisors, medical students and doctors in training, along with equitable access to educational resources.

The NZMA recognises that the public hospital system has been - and should continue to be - the cornerstone of medical training in New Zealand. The NZMA supports the expansion of medical training into expanded settings beyond the traditional teaching hospital model, such as general practice, private hospitals, and university departments.

iv) Early streaming

Medical training in New Zealand is based on the notion of a doctor becoming a generalist first and specialist second. Decreasing the breadth of knowledge of New Zealand medical graduates is not in the long-term interests of New Zealand. Narrowly qualified graduates will not be able to do all the things that we currently expect our graduate doctors to do. Foreseeable flow on effects could include increased inter-specialty referral and increased overall workload. This model is not sustainable for our populations who live outside of major urban centres.

The NZMA remains opposed to early streaming into vocational training.

v) Part time and flexible training

Medical practitioners enter medical training at different stages of their lives, with different expectations of both their career and of themselves, and most with the ultimate goal of supporting a family as well as a career. Previously (and in some cases presently) many public sector jobs and training programs were structured in such a way as to make obtaining flexible or part-time roles very difficult. This has at least in part contributed to the appeal of locuming.

The NZMA supports an increase in the number and variety of flexible, part-time and job-share employment roles available to both male and female practitioners, and considers the availability of parental leave to medical practitioners as vital - regardless of gender or sexual orientation.

Further, the NZMA advocates for greater acceptance of medical practitioners' family roles by specialist medical training programs in order to make more manageable the combination of family life and training, and to improve retention of trainees. In particular, it is necessary to recognise part-time and flexible employment arrangements as being suitable as accrued training time for specialist trainees

d) Medical student numbers

As noted above, the MTB has recommended that the number of medical student places be increased by 100. The current government has indicated it intends to increase numbers by 200. NZMA has been of the view for some time that medical student numbers should be increased. We suggest that further New Zealand medical school positions may be required, because we currently register four overseas trained doctors for every New Zealand graduate each year. If medical student numbers are to be increased, however, we provide the following recommendations:

- Any increase must be of *funded* medical places. We oppose full or partial fee paying systems for reasons of equity, educational capacity, and for the negative effects they would have on professionalism and workforce distribution. The already unrepresentative medical student demographics would only be more skewed.
- Any increase in medical student numbers must be adequately resourced. It is absolutely vital that the quality of education is not compromised at a pre-clinical or clinical level. Substantial funding will be required to support the provision of appropriate resources and learning opportunities, for an environment that is already being stretched.
- Any increase in resourcing must not be funded by further increases in medical student fees. Though an increase in medical student numbers will bring further income from each student, this will most probably not be enough to cover the further costs required by increased resourcing. It is important that any difference is absorbed by the University and by Government funding, rather than the dispersion of costs to the entire medical student population who already face significant issues with debt. Furthermore, it should be noted that increased levels of medical student debt have a perverse effect on doctor retention.
- Any increase must be done in an incremental fashion so as to allow medical schools, district health boards, and training programmes to adapt and minimize the bottlenecks seen with the “tsunami” of increased medical students in Australia. Guarantees need to be made that any extra students will be supported beyond graduation. Employment positions and training posts need to be developed for extra graduates to fill. Colleges will need to be consulted with regard to standards as well as capacity to accept increased numbers of vocational trainees because most of our specialist colleges are in fact Australasian Colleges with a head office in Australia.
- Consideration needs to be given to where future demand for medical practitioners is likely to be strongest given changes to New Zealand demography.

The NZMA believes we should aim for self sufficiency in respect of our medical workforce. NZMA supports the Government’s decision to increase medical student places by 200 per year, and believes that further increases may be necessary subject to the caveats noted above.

f) Funding and resourcing of MET

Training doctors costs money but is necessary. In simple terms, this means that there must be adequate resourcing for the training institution, for the trainers, and for the trainees to maintain high quality education.

Currently the CTA is the means by which the value of training doctors at a postgraduate level is allocated to the health sector. There are limitations to this funding pathway which means that DHBs do not necessarily value medical training, and boards are not responsible or accountable for training.

Trainers are often senior clinicians of various types. Trainers require sufficient remuneration, time protection and resourcing to provide quality training.

Trainees incur many financial costs of training. Medical students are expected to meet these or borrow. Trainee interns are supported by Vote Education with the trainee intern grant, which recognises these costs. For doctors in training, many costs of training are currently reimbursed by DHBs as part of the employment contract of resident doctors.

The NZMA believes medical training should become a key performance indicator of DHBs. This ought then to attract appropriate central funding as well.

The NZMA supports the minimization of financial costs to medical trainees at all levels.

g) Locums

Freedom of association is a fundamental right of workers. Employment contracts between an employee and employer must be allowed to include all models of employment including salary, wage, casual, short term, long term and permanent contracts. Most pre-vocationally qualified doctors are employed in a salary based model. Some however work on a short term contract or locum model. NZMA believes that this type of model should always be available as it is currently a flexible option for RMOs to work part time, and there will always be some need for doctors to fulfil positions at short-notice and for short time periods.

RMOs working as locums are frequently described as a problem, whereas the current high rate of locum workers is actually a symptom of true workforce shortages coupled with workplaces that offer little flexibility, and frequently treat locums better than permanent staff. The problem is the shortage and poor conditions, not the doctors who have responded to these adverse conditions. The key to improving this situation is to address the underlying causes of the shortages and improve working conditions.

The current over-reliance on locums is an inefficient use of resources that would be better spent improving conditions for salaried doctors. To redress this balance NZMA believes that there is a need for more high quality hospital positions with a training focus that lead an RMO to choose to stay in salaried hospital positions. Long term locum work also has limited educational benefit for RMOs, and these doctors often do not progress efficiently into specialist training.

The NZMA believes the current high rate of locums is a symptom of an underlying workforce shortage. To redress this issue, more high quality hospital positions with a training focus should be created to encourage RMOs to stay in salaried medical positions.

Although there is a current over-reliance on the locum model, there will always be a place for this model to continue.

h) Implications of debt

The high level of student debt continues to be a significant factor² that

- discourages those from lower socio economic groups, Maori and Pacific Islanders from studying medicine, and
- encourages doctors in training to leave to work overseas or on locum contracts³.
- Encourages doctors in training to choose their vocation based wholly or primarily on financial imperatives.

NZMA supports

- *the previous government's decision to make student loans interest free for those staying in New Zealand more than 183 consecutive days per year and*
- *the "voluntary bonding" scheme set up by the current government to offer incentive based debt relief to doctors working in hard-to-staff locations and specialties.*

i) Medical Training Board

As noted elsewhere, in December 2007 the Medical Training Board formally came into existence. NZMA gives the MTB its full support and furthermore states that the Board needs to be given the necessary power to ensure its recommendations are put into effect.

j) The Curriculum Framework

³ See for example *The Impact on Students of Adverse Experiences during Medical School*, Wilkinson TJ et al. *Medical Teacher*. 28(2):129-35, March 2006 and *Student Debt Amongst Junior Doctors in New Zealand; Part II: Effects on Intentions and Workforce*, Moore, James et al, *NZMJ*, Vol 119 No 1229, 17 February 2006.

In 2008 the MTB released a consultation document on the current curriculum and which proposed a new framework. This was based on the Australian Junior Doctor Curriculum Framework but goes further in setting competency levels to be attained as a possible assessment method.

While we appreciate the work done on this, the NZMA does not believe the proposed system is manageable nor are we certain that this new curriculum is necessary.

The requirements set out in the Curriculum Framework are too extensive and it is doubtful that a trainee would be able to complete all of the requirements in the set timeframe, thereby pushing out the length of time spent in pre-vocational training. We also do not consider that all of the competencies are relevant to all of the trainees and suggest that something less than the full complement of competencies listed may be more appropriate, notwithstanding our support of the idea of a pluri-potent doctor. RMOs are already highly burdened and this curriculum is likely to increase that burden. Similarly, while levels of supervision as indicated in this document are appropriate to RMOs, as doctors gain experience that same level of supervision is no longer necessary.

Moreover we are concerned that New Zealand does not have sufficient resources to support this new curriculum. In order to test that these competencies have been met New Zealand will need considerably more training done than is currently the case, placing a very high burden on SMOs. As the system is currently barely coping with demand, and that demand is soon to increase with a rise in medical student numbers, we do not believe we will be able to meet the yet greater demands placed on trainers by this proposed system.

We also do not think that this new curriculum is necessary. Although there are currently problems in terms of meeting training requirements, it seems to us that if current Medical Council standards were achieved by DHBs as a result of resources being increased so that trainers had available time to train, and through DHBs being accountable for training, the majority of our issues with training would be resolved.

In our view any changes made to the curriculum should focus on increasing the amount of supervised clinical time and reducing the amount of time spent on paperwork and trolley pushing. We agree that an element of competency-based training being added to the pre-vocational years would be of great benefit, however we do not want to see such an increase occur to the detriment of the apprenticeship model which underlies the training of doctors in New Zealand.

- *The NZMA does not support the proposed curriculum framework as drafted in the MTB's 2008 consultation document.*
- *Changes to the curriculum should be focused on increasing the amount of supervised clinical time.*
- *An element of competency based training being included in the prevocational years would be beneficial.*



Approved by the NZMA Board September 2009