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RNZCGP/
HWNZ /
MCNZ

By email: gpeproposals@hiirc.org.nz

Workforce Requirements for New Models of Service Delivery: Proposed Changes to the General Practice Education Programme

Thank you for the opportunity to provide feedback on the proposed changes to the General Practice Education Programme (GPEP).

The New Zealand Medical Association (NZMA) is generally very supportive of the GPEP training scheme review. While we have a number of comments to make, and at times may suggest changes, these should not detract from our overall support. We feel the general direction of the changes is excellent and provides for future workforce requirements with due acknowledgement of the needs of trainees.

Views of steering group

We note that when this matter was first being discussed a steering group was established to consider the issues. We were disappointed that the project group, responsible for developing the changes, chose to abandon ongoing involvement of the steering group, particularly as we understand that the steering group's initial views were fully incorporated. With additional input the final consultation document could have been better developed as the document only reflects some of the steering group's ideas offered before it had a chance to fully formulate its advice.

Generalism

While in principle we support the move towards greater generalism, we believe that the proposal should be more balanced and less prescriptive. For example, trainees should not be expected to show competence in all aspects of general practice especially in areas of special interest that they may never practice in. We also agree that trainees should be trained more broadly than is the current situation but only to the point that makes them excellent as *general* practitioners. Trainees wishing to develop specialist scopes within general practice should be encouraged to take on further specialist study but this should not be a core training requirement.

Hospital training

We support the principle of further periods of hospital training in areas relevant to general practice but the scheme should appropriately recognise any previous training in relevant hospital specialities. That is, if a trainee has already successfully undertaken additional 'runs' in PGY2 or later that would normally be required as part of GPEP training, the trainee should

be given credit for this experience and not be required to repeat the training merely for the purpose of course requirements.

Finally, it must be recognised that the quality of hospital experience provided to GPEP trainees may be variable depending on both the DHB and the speciality's interest in providing worthwhile GPEP training. It is also very apparent that the GPEP trainee has a relatively short period of time in the hospital to be exposed to a broad range of skills. To be of most value this period must be developed as a well thought out constructive and cohesive module of training rather than simply service provision.

Advanced competency model

Paragraph 4.2 and following sets out the proposed development of advanced competency modules. In order for these to succeed we note that you will need the support of the specialty colleges. GP registrars have expressed considerable concern about the need for support, especially if things go wrong while the trainee is carrying out his/her 'advanced competency' work. Specialists must be there to provide that support during this time, but should also be able to offer collegial support to any general practitioner practicing in an advanced competency.

We would also like to see an advanced competency model developed in Te Reo, in keeping with the principles of the Treaty of Waitangi.

Funding and infrastructure

Funding, remuneration and terms and conditions are not covered in this document but these are very important and will impact significantly on the success or failure of this proposal.

In terms of funding, we note that the proposal anticipates that general practitioners of the future will provide leadership of multi-disciplinary teams, with some general practitioners taking on roles as consultants. As such these general practitioners are unlikely to spend as much time seeing patients. Trainees who train in these new roles are similarly likely to spend less time in direct patient consulting. The cost of general practice training however, is at least partly met by trainees undertaking some consultations. From a business point of view general practice could not therefore afford to support training costs without a dedicated funding stream. Thought must be given to appropriate funding models.

From a strategic perspective we acknowledge the usefulness of general practice experience for doctors in training, but have major concerns over the capacity of general practice to absorb the increased burden of trainees undertaking periods working in general practice that will result from both this model, and the changes to prevocational training with possible mandatory "community" runs. If general practice is to take up this increased burden then some form of funding will need to be provided.

Turning to remuneration and terms and conditions, as you will be aware, the decision by a GPEP trainee to undertake a hospital run has remuneration implications. We are firmly of the view that remuneration for a GPEP trainee, whether they work in general practice or undertake a rural or an urban hospital run, should continue on the same remuneration and terms and conditions regardless of the move. Moreover those terms and conditions should be on a par with those offered under the current RMO MECA. A current negative factor in considering general practice as a vocation is the remuneration and its inconsistent payment systems.

Flexibility

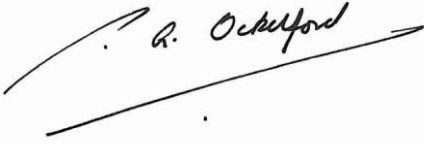
We advise that for the system to work it needs to be very flexible. We therefore suggest that as a starting point consideration is given to the rural training model.

Rumours

As can be expected with any proposed major change, the rumour mill usually gets ahead of the development and it is no different with this proposal. Currently the “understanding” of trainees is that the GP training review proposes to simply install the UK training model in New Zealand. Feedback they are given is that the UK model is “known” to be problematic. In order to stop this in its tracks it may be an idea in reporting on this, to set out the similarities and differences between the two schemes. The proposals need to be ‘marketed’ effectively to potential trainees to ensure buy-in.

We trust our comments are helpful and would be happy to meet to discuss any of the above issues further.

Yours sincerely

A handwritten signature in black ink, reading "Dr. Ockelford". The signature is written in a cursive style with a long horizontal stroke underneath.

Dr Paul Ockelford
NZMA Chair