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Prevocational Training Requirements for Doctors in New Zealand

Thank you for giving us the opportunity to comment on this significant issue. We also appreciate the time take by yourself, Mr Pigou, and Dr Adams to meet with us to discuss the issue in detail.

Firstly we commend you for reviewing the prevocational training years which in our view is long overdue. We are well aware that:

a) the colleges are concerned about the quality and breadth of training provided to trainees prior to entering into their vocational training schemes
b) trainees report dissatisfaction about the variable nature of training experienced in PGY1 and PGY2 years.

We support this review and we warmly agree with the Medical Council of New Zealand's (MCNZ's) desire to implement positive change in the prevocational years. We also agree with the issues that MCNZ has identified, namely:

a) the lack of vertical integration along the continuum of education and training
b) tensions between service demand and training needs
c) a hiatus in training during PGY2
d) the need for more emphasis on obtaining broad based core competencies
e) training being too hospital focused and not on the community setting
f) the use of PGY2s for locum positions has resulted in some safety concerns
g) the lack of accountability of DHBs which have no performance links to funding.

We would add to point f) above that if new general registrants are taking jobs for which they are inadequately experienced, safety becomes a separate issue to the general objectives of general registration. Addressing these safety concerns may require adding detail to the scope of practice for general registrants. This should not impact on the requirements for all doctors, most of whom continue in well-supervised jobs for years after registration.

Our chief concern is that, although the MCNZ has highlighted these pertinent concerns, the suggested solution of simply extending the duration of runs will not resolve the issues

presented and will instead create a new set of problems with further PGY1 & 2 dissatisfaction.

Before addressing the questions raised in the consultation document we provide the following general feedback.

We had initially understood that by adopting one of the four proposed options, the MCNZ believed that these problems would be resolved. This caused us some concern as we can not see how the proposed structural changes would resolve many of the above issues. From our discussions with you, however, we understand that the structural changes proposed need to be seen in the context of a broad package of changes, including changes to the curriculum. We accept that, but at this point we remain uncertain as to the advantages of the changes proposed.

Four month runs
We note that all of the proposed options are based around changing the run length from three months to four months. While there is no evidence of improvement in the quality of training, we understand that the MCNZ's view is that increasing the run length will improve the quality of pastoral care for trainees. We also understand that the proposal was heavily influenced by the UK Foundation Programme.

With respect we are uncertain that a move to a four month run will be an improvement for DHBs, Provisional Registrants or General Registrants.

In many cases the existing mandatory three-month runs provide excellent training, although other runs can be of low quality. Most of the concerns about service and training tension are due to low quality runs, where the service component involves administrative tasks without assessing patients. We believe runs should not need to be longer than three months if they are of high quality, and thus the proper accreditation of high quality runs should be of highest priority for MCNZ.

Furthermore most of the possible clinical exposure from a run will occur within the first part of the run, and later weeks will have a strong repetitive element to the clinical experiences. Extending runs to four months will actually mean that trainees will have less variation in training runs, less career exposure to inform career decisions and less clinical exposure overall.

Effect on the District Health Board (DHB)
Certainly the changes will cause considerable problems for hospitals in terms of resources, as the longer runs in areas specified as essential for registration will mean more competition for those jobs, and a smaller workforce wishing to work in other areas. This would potentially provide a new locum market as DHBs would be forced to find extra staff to cover for the loss of the first year workforce.

Effect on the provisional registrant
The provisional registration year remains a very challenging and stressful year for many doctors-in-training as they gain new skills and responsibilities. The experience they have in their runs may contribute to the challenges faced. The extension of runs by a further month may appear, from a prima facie perspective, to be a useful mechanism to implement pastoral guidance and apprenticeship skills.

However, this does not solve the inherent challenges in education and service delivery that each house surgeon faces. Furthermore, we are concerned that the operational implementation of this run extension from each DHB will not provide any qualitative benefit and in fact may make their runs more onerous. After all, a poor run will not be improved merely by a run extension. This may in turn provide a perverse incentive for prevocational trainees to leave for the locum population.

Effect on the general registrant
We envisage that the proposed changes for provisional registrants will have a flow-on effect for general registrants. General registrants may be forced to cover previous PGY1 positions and, as a result, senior house officer and junior registrar positions will be downgraded to undertake this work. This would not improve the general registrant training experience.

Community care and emergency medicine
We note that all four options encourage an increase in trainees undertaking either community care or emergency medicine.

We agree that exposure to the undifferentiated patient would benefit the provisional registrant. In regard to community care we understand that the aim is to encourage more trainees to do a stint in general practice or other community care. While we applaud the decision to increase the number of runs taken in general practice, the option again poses huge logistical difficulties. There is an insufficient number of general practices with extra capacity (in terms of both training time and extra space) to meet such an increase, at least in the short term. We understand that this is one of the reasons why the focus has moved to “community care” rather than general practice exclusively. Still, we will be interested to see whether the change in focus will solve these logistical difficulties. Also, as we noted in our submission to Health Workforce New Zealand (HWNZ) in regard to the proposed changes to the General Practice Education Programme (GPEP) training, if general practice is to take up this increased burden then some form of funding will need to be provided.

A similar concern must be raised for emergency medicine and how to logistically funnel all provisional registrants through the single department. We are concerned that this will result in “queues” and delay general registration while doctors wait for places in their required runs.

Alternative options
While we have noted the difficulties with a focus on the move to three or four mandatory runs in terms of capacity, we support the choices proposed for the mandatory runs.

On the other hand, at this point in time, we do not support the move to four month runs but may be persuaded on being shown evidence to support this change. Instead we think that the status quo should remain in terms of run length but that four mandatory runs could be applied at PGY1 year, these being general medicine, general surgery, community care and emergency medicine.

Though our members have heard many negative experiences from the UK Foundation Programme, one positive element would be the introduction of regular, electronic, mandatory reports from more senior colleagues on a medical team. For instance, a registrar needs to complete an electronic form for their house officer once every four weeks or so. If this

system were adopted, thorough consultation would be needed to ensure this process was user-friendly, accessible, quick and relevant.

While making the four three-month runs mandatory for PGY1 should mean that doctors are provided with the breadth of learning necessary prior to registration, it does not necessarily mean that quality is improved. In respect of this, we believe some element of competency testing needs to be introduced.

NZMA does not support increasing the period before registration
We do not favour an extension to the registration period as per options two and four. Aside from upsetting future doctors as they see the goal posts move further out in favour of increased bureaucracy, increasing the length of time before doctors achieve registration is likely to place increased pressure on second or third year trainees, as there will be a smaller pool of fully registered doctors to supervise TI prescribing. The proposal for a 16 month registration period, while posing logistical difficulties for the DHBs, is not really an improvement over the proposed two year registration period as trainees will not be able to apply for vocational training until the new year anyway. At present, trainees have the ability to go directly from completing their PGY1 year into a vocational training programme and we would not want to see this changed.

We also do not support Option C which involves the creation of a halfway registration between provisional registration and general registration. While this has the benefit of implementing qualitative curriculum changes, without the additional concerns of rolling out a significantly revised roster/workforce, the disadvantage is that this will create a new registration variant and limit PGY2 flexibility.

Oversight of PGY2
One of the concerns raised in the consultation document was the lack of oversight of PGY2. While we support PGY2 continuing to be an easier year than others, with no substantive exams to sit, we believe the year could be improved by introducing some competency based testing as per the Australian curriculum framework. The key to any changes however, will be the ability to keep the year slightly less demanding than those before and after it, but with some additional competency tests included in the year to ensure that quality training continues.

Need for evaluation
Whatever changes the MCNZ ultimately choose to implement, the impact will need to be carefully monitored and evaluated. We trust that you will be considering how to do this before you choose to implement these changes rather than some months or years later.

The above comments having been made we turn now to address the consultation questions directly.

1. Are there any important issues and drivers we have either omitted or overstated?
Aspiring to excellence
We strongly believe the education and training component of the PGY1 and PGY2 years should not be framed as a minimum standards approach but rather with developing excellence. Aspiration for excellence for a doctor is a separate issue to the MCNZ role of maintaining minimum standards through registration.

Autonomy as a doctor
Doctors-in-training value their autonomy and unless there is significant evidence, will not appreciate the potential restrictions placed on them. Although we respect the possible need for pastoral care in PGY2, this must be tempered with the desire for many PGY2s to seek time out of the strict enforced model of progression from their prior six – seven years of training.

We have commented above on our views of the proposal to extend the runs to four months.

Provision of trainer support
We strongly believe that the DHBs must give senior clinicians the time and resources to provide an improved educational setting for the pre-vocational trainee. We do not know how MCNZ can institute change at this level, yet this must be the first change to occur.

2. Do you agree with the objectives and principles?
We look forward to the development of a curriculum that uses the Australian Curriculum Framework for Junior Doctors as a template which fits in well with our view to strive for excellence.

As mentioned, we do not agree with the principle that the extension of runs will benefit training. We appreciate that in overseas contexts, such an extension has helped. However, within the New Zealand DHB infrastructure context, service provision is the dominant daily activity of most doctors and there is insufficient evidence to assume that extending a time-based learning model will guarantee the breadth of learning that the MCNZ desires[1].

3. Should there be mandatory runs? If so, what should they be?
We believe that if there need to be mandatory runs then these should reflect the issues that MCNZ feels are lacking in the current model; namingly the desire for more broad based core competencies and enhancing the community care setting. If these runs are required then we favour runs that expose the PGY1 & 2 to the undifferentiated patient – such as general medicine, emergency, community care and surgery in general.

4. What is the appropriate length of training?
As previously noted, we do not necessarily agree that the length of prevocational training should be defined by a strict measure of time, a whole year should be sufficient to assess competence in well planned clinical settings for adult based learning.

This hinges on an improved integration between undergraduate and postgraduate years. Potential innovations such as medical student registration may streamline this learning process.

We would also link this question back to the autonomy of our doctors. A further extension of registration would most likely disappoint many of our colleagues who have already undergone seven years of training.

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[1] At present, service demands of junior doctors are often non-patient contact time and when available, senior doctors are often too busy with their demands to extend an outpatient consult for the sake of teaching.

5. What are the consequences of each option?
The critical consequence from all of these options is the strain this will place on current DHB infrastructure. There are already a finite number of runs that fit the required criteria by the Medical Council. At present, if all PGY1s undertake the runs mandated by the Medical Council with an extended duration then there will be insufficient slots for run allocation. We would contend that this would cause four major problems.

The changes will:

a) force DHBs to hire more locums to fill after-hour roster requirements. This would be a perverse outcome of the proposed changes
b) artificially extend provisional registration whilst doctors "wait in line" for mandated runs. This would have a significant effect on morale and create a further reason to leave New Zealand
c) strain the current service delivery for runs outside of the MCNZ requirements. Responsibility would then be transferred to the Senior House Officer and registrar population and hinder their own training opportunities
d) still limit the breadth of experience suggested by the Australian Curriculum Framework.

These problems are not insurmountable but we would urge the MCNZ to consider the ramifications that will occur without necessary investment being put into resourcing and trainer education.

In terms of each option - the advantage of Option A is that this is an evolutionary change. It will allow the implementation of the national curriculum and provide a springboard into shaping community care as a viable flow-on path for trainees. The disadvantage of Option A is that trainees must choose between community care and emergency medicine. The value of community care is the exposure to the truly undifferentiated patient which is the cornerstone of medical training and this may be missed.

Option B incorporates both community care and emergency medicine - hence it's advantages. We feel that the disadvantage is the 16 month program. We believe that one year is sufficient to complete provisional training requirements for most doctors.

Option C involves the creation of a halfway registration between provisional registration and general registration. This has the benefit of implementing qualitative curriculum changes without the additional concerns of rolling out a significantly revised roster/workforce. The disadvantage is that this will create a new registration variant and limit PGY2 flexibility.

Whilst we applaud the need for increased emphasis on mental health, as offered in Option D, we question the current educational value of institutional mental health runs at present. The typical house surgeon experience suggests that these runs are quite "medically focused" and there is rarely a provision for exposure to common, community issues relevant to the specialty. We also have reservations about the length of this provisional registration and the likelihood that many PGYs will have to "wait in line" for an even longer duration. While the floodgate of doctors moving to Australia for training positions looks to be closing over the next few years, the change will nonetheless create an additional incentive to leave New Zealand for Australia after PGY1 where they then will be registered immediately. As noted elsewhere it is also likely to impact heavily on morale.

6. What is your preferred option and why?
Option A is our preference from the available options because it allows an evolutionary change and offers PGY1s experience with the undifferentiated patient, whether in emergency or in community care, something that is currently lacking in many first year runs. However, it also offers the house surgeon the opportunity to obtain full registration within a year.

Reflecting the plurality of the NZMA, a significant minority have also advocated for Option C. This reflects the logistical challenges if a large proportion of the RMO workforce is funnelled into specific runs within a short time frame. Those runs would become overloaded whilst runs deemed non-PGY1 will have to be serviced by other RMOs. Those challenges are real and we are concerned that a cohort of provisional registrants will be adversely affected by these changes.

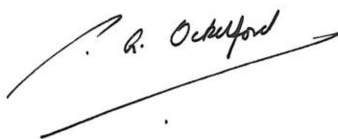
7. Is there an alternative option that is not outlined in this paper that would be consistent with the objectives and principles outlined in this paper?
Within the scope of this paper we support the choice of general medicine, general surgery, community care and/or emergency medicine for mandatory runs within the framework of one year.

We would also conclude that simply extending a time-based assessment will not benefit the quality of training for an RMO. Instead we urge the Medical Council to instead examine the quality of *each individual run* that a PGY1/2 goes through. Within the framework of each run, we believe that this is an ample timeframe per run to improve the quality of training through the implementation of a competency curriculum, improving exposure to undifferentiated patients and providing senior staff with allocated time for teaching.

Suggestions for each run may be two Mini CEX cases per specialty experience or poster, oral or written presentations to a peer review group, or the creation of weekly house officer GP clinics.

We trust our comments are of help and we would be happy to work with you further on this.

Yours sincerely



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