NZMA
New Zealand Medical Association

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By email: review@rnzcgp.org.nz

Review of the delivery of general practice vocational training

Dear Tim

The New Zealand Medical Association (NZMA) welcomes the opportunity to provide feedback to the Royal New Zealand College of General Practitioners (the College) on the review of the delivery of general practice vocational training.

1. The NZMA is the country's largest voluntary pan-professional medical organisation with over 5,000 members. Our members come from all disciplines within the medical profession and include general practitioners, doctors-in-training, specialists, and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders. Our submission on the College's review of training delivery has been informed by consultations with our Doctors-in-Training Advisory Council (DiTC), General Practice Advisory Council (GPC), and the NZMA Board.

General Comments

2. The NZMA congratulates the College on its comprehensive report on the review of training delivery as well as the extensive consultations it is undertaking in order to progress this major project. We acknowledge the increasingly important role that general practice is playing in New Zealand's health system and are also aware of the many challenges it faces. We firmly believe that creating and sustaining a high quality general practitioner workforce is paramount. While many of the options being proposed in the review could have a positive impact in this regard, several proposals are likely to have divergent implications for different stakeholders in a complex funding environment. As the NZMA is a pan-professional medical organisation, our submission incorporates the perspectives of GP trainees as well as that of GP teachers and employers. In many instances, these perspectives are aligned. Proposals where these perspectives differ are specifically identified in our submission.

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3. Our association is broadly supportive of measures to increase the overall number of training hours in the general practice training programme to bring it more into line with other vocational specialities. However, we recognise that achieving this will be associated with increased costs. We urge funders to make adequate provision to cover these costs such that GP employers and supervisors do not incur additional costs and/or are appropriately compensated for the increased teaching time and possible decrease in service provision that might arise as a result of the proposals under consideration. Our detailed responses to the various options in the consultation document are given below.

Specific Comments

Number and spread of training hours

4. The NZMA is strongly supportive of proposals to increase the hours of education across the training programme. Formal teaching in the existing training programme is currently considerably less than for other vocations in New Zealand, and less than for GP training in comparable overseas jurisdictions. This needs to change. However, we would not want to see quality of learning traded off for the sake of quantity.

5. We note that the College proposes delivering increased hours of education *"within the current financial constraints"*. We are somewhat sceptical that this can be achieved without compromising the quality of teaching (and ultimately, of the quality of care provided by general practitioners). As such, we suggest that securing greater funding from Health Workforce New Zealand (HWNZ) continue to remain imperative. While we are cognisant of the current fiscal constraints, ensuring a highly skilled general practitioner workforce is central to the provision of a strong primary health care system, which in turn is central to improving the health of all New Zealanders. We believe that it is reasonable for GPEP registrars to receive comparable funding for training from HWNZ as trainees on other vocational training programmes.

6. There is broad consensus that while more formal teaching in GPEP years 2 and 3 is desirable, this should not be accompanied by a reduction in teaching in GPEP year 1. We suggest that the majority of the basic curriculum should continue to be taught in the first year of training, with subsequent years in the programme used to consolidate existing knowledge and undertake more advanced training. We do not support the proposed 50% reduction in small group seminars in GPEP year 1 as this type of learning is well suited to the first year of training. We recommend a continuation of the seminars in GPEP year 1. It is felt that the increase in teaching hours in GPEP years 2 and 3 should come from small group work (e.g. learning groups), immersion training (protected teaching time within practices), CME and online education. Specific concerns regarding the capacity of practices to provide this increased teaching time as per the models of funding being suggested are addressed in the next section.

Employment and use of funding

7. The NZMA strongly agrees that equitable education funding is obtained for the GPEP programme in comparison with other vocational registrar training programmes. In order to be better informed, we would like clarification on how much educational funding is currently obtained from HWNZ for the GPEP programme compared with hospital RMOs/trainees at similar levels.

8. We note that the College is proposing two options with regards to employment and use of funding: i) Status quo – College employs registrars for GPEP year 1, with practice employment in GPEP years 2 and 3; ii) Alternative model – College employs GPEP registrars for the full three

years they are on the programme. The NZMA believes that each of these two options is associated with various merits and drawbacks that need to be weighed up against each other.

9. Benefits of the status quo include that it allows good flexibility for those trainees who are part time trainees or spend part of their time working outside general practice (e.g. in family planning or sexual health). Remuneration is another factor which requires consideration. In their first year of training under the status quo, most GPEP year 1 trainees experience a significant pay cut from what they were earning in the hospitals. However, the favourable remuneration in the subsequent years under the status quo offers these trainees the chance to offset the financial disadvantages they faced during GPEP year 1. Nevertheless, a major drawback to the status quo is that it is very difficult for the College to stipulate mandatory teaching/learning time within work hours when they are not the employer. As such, there is a large variability in learning experience within practices. In many cases, GPEP years 2 and 3 trainees are just working as any other GP in the practice.

10. With respect to the alternative proposal of College employment for the full three years, a major benefit is that it should make it much easier for the College to set training/learning time in GPEP years 2 and 3. An additional benefit would be the guarantee of work in an accredited practice during the second part of the training programme – though further information is necessary on the ease of finding work in an accredited practice to reliably ascertain the magnitude of this benefit. Nevertheless, it is likely that this alternative model would appeal to many younger doctors entering the training programme in PGY3 or PGY4 who have previously been party to the DHB MECA as it would remove the need for them to sort out their employment, an experience that some young trainees find quite stressful.

11. The reduced remuneration associated with the College employment option has been identified by the DiTC as a major factor undermining support for this option. As previously stated, remuneration of GPEP years 2 and 3 under the status quo is perceived as offsetting the financial disadvantage of GPEP year 1. Receiving payment equivalent to the MECA rates (as is being proposed) would represent a considerable reduction in remuneration for many trainees compared with the status quo. While this is clearly perceived as a disincentive by the DiTC, our GPC are in favour of GPEP trainees being remunerated in accordance with the MECA scale throughout their training programme.

12. Compared with the status quo, it is felt that the alternative model being proposed would be less attractive to those who are seeking part-time training options (e.g. those requiring maternity leave or those with childcare obligations). It is also likely to be less attractive to older doctors (PGY5+) who have been working in other specialties and prefer to work part time in general practice while continuing part-time practice in other areas. Many of these doctors are likely to prefer the flexibility of making their own employment arrangements. This proposal could limit options for those wishing to continue to work in other community areas. In addition, this model is also likely to represent a disincentive to enter the general practice training programme for those who have already been working in general practice under general registration and who would therefore take a significant pay cut by doing GPEP years 2 and 3. It is also likely to pose challenges for those trainees who need to move regions every year (e.g. those trainees with partners on other training schemes). Given the potential drawbacks identified above, we would specifically like to know more information about how the alternative model would apply to part time trainees, and how flexible work options will be managed (and funded) for those who work in other areas.

13. The NZMA holds major concerns regarding the funding of general practice training for both the status quo and proposed alternative option. With respect to the proposed alternative, we

note that the consultation document states that *"HWNZ would continue to pay at the same rate as currently, but less of that money would go towards employment as this cost would be shared by the practice"*. It is felt that even the current level of funding for training is inadequate, especially for GPEP years 2 and 3. Rather than accept the current amount of funding, we believe that it is imperative to make the case for additional funding from HWNZ to ensure a training programme that delivers on both quality and quantity, to bring the New Zealand general practice training programme up to the same level as other vocational training programmes in New Zealand as well as general practice training programmes overseas.

14. We note that under the proposed alternative model, trainees would be subcontracted by the College to the practice in which they train. *"The practice would pay the College for the services provided by the registrars".* Our GPC has expressed major concerns that this is simply not a realistic proposition, especially in the case with GPEP year 1 trainees. Although the consultation document suggests having multiple levels of registrars to mitigate against the service loss from year 1 trainees, 'vertical integration' is simply not feasible for a number of practices. Providing the requisite teaching and supervision for several registrars in a single small practice, for example, is not tenable. Furthermore, having multiple registrars at a single practice could undermine continuity of care for enrolled patients, particularly if these trainees entered and left the practice at different time points during the year.

Start point, length of training programme and other vocational scope requirements

15. We note that two options have been proposed: i) Continuation of the status quo where registrars would be interviewed for the programme when they wished to enter general practice, which is likely to continue to attract registrars at PGY5+; ii) Encourage engagement with the programme from PGY3. The NZMA believes that while entering GPEP from PGY3 is a reasonable idea, having more experience before embarking on general practice training is desirable.

16. The benefits of the status quo are that many doctors entering GPEP are very experienced (PGY5+) and bring a wide range of both medical and life experience to their GP work. Furthermore, many RMOs choose general practice as a career pathway post PGY3. There are many reasons for this. For example, it may be because they don't get onto another vocational training scheme. Alternatively, they may change their mind about a career path after working in another speciality for a few years. Others may specifically select general practice given its greater scope for more flexible training and more 'acceptable' work hours.

17. We note the proposal for an option to complete PGY3 within a DHB. While this would enable trainees to complete a 6 month attachment in another vocational scope, there are some concerns that it would be used primarily for this purpose, and not to gain exposure to other core attachments such as obstetrics and gynaecology, paediatrics, ED and orthopaedics, from which invaluable experience could be gained to take into the general practice training programme. There is also clearly the need for HWNZ and DHBs to sort out the funding requirements of a PGY3 training year being completed within a DHB.

18. While a 36 month training programme (as is currently the case) is perceived as a good length by our DiTC, the GPC takes a different view, suggesting lengthening the training programme to 4, possibly even 5, years, with deferment of the Primary Membership Examination (Primex) to 18 months or 2 years. The rationale for this suggested lengthening in the training period is to make general practice training comparable with other vocational training in New Zealand, to ensure a high quality training programme, and to change the widespread perception among RMOs that general practice is a 'soft option'.

19. The proposal relating to keeping the time spent in 'traditional general practice' during GPEP training at 18 months has generated some debate. There is a view that this requirement should be increased to 24 months, with an exception for those doing dual training (e.g. rural hospital medicine and AMPA/CUCP programmes). As GPEP year 1 is currently 12 months, if this requirement stands, it would theoretically be possible for trainees in their second and third years to undertake only a further 6 months of 'traditional general practice' and still get their fellowship. Doing a minimum of 50% of training in a vocational scope in order to get fellowship is not considered adequate. Indeed, as already stated, our GPC are of the opinion that the existing training programme should be made longer and more demanding.

20. There is broad support for the concept of completing six months in either high needs, Māori/Pacific or rural practice during training. However, the College needs to clarify how it envisages this scheme would work, as many trainees would presumably do this stint in GPEP year 2, not GPEP year 1. Furthermore, we have some concerns that making this a compulsory requirement could be a potential disincentive for some trainees.

Registrar placements

21. We note that one of the biggest challenges facing general practice is the need for GPs in all regions of New Zealand, both urban and rural. The NZMA agrees that the current model of trainee placement allocation should be retained, and continues to focus on promoting rural and high needs practice placements to trainees. There is some ambiguity over what is currently being done to promote rural and high needs placements in GPEP year 1 and we would be interested in knowing more about this. The NZMA agrees with the College's proposal to investigate sponsorship options for rural or high needs placements, either for the trainee or the practice (or both). We suggest this idea could be extended to sponsorship for PHOs.

22. We believe that it is important to continue to provide face-to-face training in all 11 regions, even if the number of trainees is low in some areas. The concept of virtual clusters may be a useful way to supplement face-to-face teaching in high cost locations, however, it is important to ensure that such learning is comparable with those in larger centres. We do not believe that virtual learning clusters should replace actual small group learning sessions.

23. We note that the College points to research suggesting that GP trainees are likely to remain in the location at which they trained after gaining their fellowship. We believe that this is at least partly due to the high number of trainees who are older when entering the GPEP programme. Such trainees are less likely to move due to factors such as having bought a house in the area, having a family and the need to accommodate a partner's work considerations. If more trainees enter GPEP at PGY3, it is possible we would see more doctors moving location after their training as the above factors would be less relevant for a younger cohort.

24. There is little support for the idea of a compulsory placement in either a high needs, a rural or a Māori/Pacific setting, although the NZMA agrees that more should be done to encourage such placements. It was noted that having seminar days during the middle of the week is difficult for rural trainees and the requirement for them to travel to these seminars makes such placements less appealing. Encouraging more of these placements in GPEP year 2 could be a way of addressing the travel issue. The lack of support for compulsory placements stems from the fact that many trainees enter general practice for its flexibility in both training locations and hours worked, and the ability to continue working in other areas. Compulsory placements would limit this flexibility and provide a potential further disincentive to training in general practice.

25. We believe that the option of clustered practices as a way of addressing the geographical spread of trainees is worth exploring. However, there are some concerns regarding how much variety a trainee would encounter if they worked in practices that were all in the same areas throughout their training. Rotating around practices with different patient demographics is generally good for building up a broad range of experience during training. Nevertheless, if this option is pursued, it will be important to retain the option to change cluster if an individual's circumstances changed.

26. We do not support the option to impose a minimum number of trainees per region and to restrict training to regions with five or more trainees. Training should still occur in all regions even if there are small numbers of trainees in order to encourage doctors to work long term in all regions and avoid discouraging trainees from entering the training programme (if they have to move from their existing region). While the option for a virtual cluster may be of value for regions with less than 5 registrars and reduce the costs associated with travel, there is a need to ensure that the learning experience is comparable to those in larger centres. Small group teaching is still preferable in all regions.

Immersion teaching and supervision

27. The NZMA strongly supports immersion teaching and supervision as the basis for training. This model is consistent with the apprenticeship model of learning articulated in our Medical Education and Training position statement.[1] While the status quo of no formal ongoing teaching within the practice in GPEP year 2 is not ideal and at odds with other vocational training programmes, we recognise the costs that greater supervision would entail. We also note that practices are currently providing, on average, around 5.5 unpaid hours of teaching for GPEP year 1 trainees, in addition to incurring reduced services with taking on year 1 trainees.

28. We have serious reservations relating to proposals for vertically integrated teaching models and a higher ratio of registrars to teachers. Teaching and supervision entails significant financial and time costs. Many existing practices would simply not be in a position to take on board multiple registrars at different levels of training. It is likely that a combination training model may represent the best option as it allows teachers and practices to determine what they can manage in terms of the number of trainees they can accommodate. Larger practices may well be able to accommodate more than one GPEP year 1 trainee and also take on trainees at multiple levels. However, this would not be feasible for many smaller practices. Further input from practice teachers and medical educators is essential regarding College proposals to change the teaching model.

Workplace assessments

29. The NZMA believes that the existing system for workplace trainee assessments functions satisfactorily but we acknowledge that it is a costly process. We note that the option to combine trainee assessments on the same day is an approach that is already undertaken in some practices. We believe that this is certainly a reasonable approach where there are multiple trainees in one practice. While the use of video conferencing to complete virtual assessments has been proposed, we believe that this could be an option in GPEP years 2 and 3, but not in GPEP year 1, and only if the trainee has not had concerns raised in their previous assessments. Its use depends on the individual GPEP trainee and should perhaps be at the supervisor's discretion. With respect to remedial visits, the suggestion of pooling visits appears reasonable; however, we believe that

[1] Available from http://www.nzma.org.nz/sites/all/files/pos_MedicalEd_2013.pdf

there should be at least 2 visits during GPEP year 1 and one visit in each subsequent year of training as a minimum requirement for all trainees.

Workshop/seminar programme

30. The current system of regional seminars is very popular among GPEP trainees. Most like the intensiveness of the seminar programme, the protected teaching time, and feel well supported in their practices. The large numbers of trainees in some regions (e.g. Auckland, Wellington and Christchurch) can mean that it is difficult for individuals to get as much feedback as trainees in other regions. However, smaller centres can also be disadvantaged in view of trainees from these centres having fewer resources (e.g. WEBS, MATCH questions and vignettes) to share within their regional group. We suggest retaining the GPEP regional seminar programme as it is, with consideration given to 'clustering' larger centre practices to get smaller groups of trainees.

31. The NZMA does not support the proposal to halve the number of seminar days in GPEP year 1. We believe that there is a clear need to have a large number of seminar days in GPEP year 1 to cover the core curriculum. This learning needs to be done early on in the training programme in order for trainees to feel confident during their consultations with patients. Most small group work (e.g. case reviews, video reviews) is already done with 5 to 10 registrars (splitting of the seminar group into smaller groups is done in bigger regions, and smaller regions don't usually have more than 10 registrars) so the proposal to increase the size of small groups is not really different to the current situation. The ability for more specialists to be part of teaching sessions is seen as valuable – whether at small group or seminar sessions. The option to deliver the seminar programme in four hub locations appears to be reasonable, although it is not clear as to how specialist teaching would fit in with this. A concern with having a large number of small groups for learning is the potential for increased variability in the quality of teaching.

Online education and an e-portfolio

32. There is generally broad support for the proposals made for online education and the development of an e-portfolio, with the following caveats. GP trainees should not be expected to fund the development of online education services through their fess, particularly as their training costs are generally not reimbursed in GPEP years 2 and 3. It is felt that accessing other providers' materials is preferable to creating college-specific materials, at least in the initial stages, although a combination of development methods would be the preferred option. The NZMA supports the introduction of an e-portfolio which should take over from the current online CPD reporting done via the College website. Possible integration with BPAC could be considered.

College/DHB interaction

33. The NZMA believes that it is useful for the College to engage in discussions with DHBs and funding providers to explore means of better championing the GPEP programme for PGY1/2 interns. We are not convinced of the value of a funded GPEP intern supervisor working in the DHBs to provide a direct link between the College and PGY1/2 interns. However, we are in favour of better access for PGY1/2 interns to a general practice setting. A GPEP supervisor working in the DHBs would, however, be appropriate if the proposal for PGY3 GPEP trainees to do a year in a hospital setting comes to fruition. This role would also benefit GPEP trainees doing their 6 month training in another vocational scope.

Community-based pre-vocational training

34. The NZMA notes that the Medical Council of New Zealand has proposed introducing the requirement for PGY1/2 interns to complete three months of community-based training. We support College engagement with the Medical Council to help develop the definitions of community-based training and practice.

35. We are in favour of expanding the existing rural general practice-based placement programme (PGGP) for PGY2/3 years, and suggest that this could also include urban placements to make it more appealing to a wider group of RMOs. The caveats to this would be to ensure that the programme ensures a good experience and remuneration is equivalent to the MECA. DHBs would also need to ensure that RMOs doing their GP attachment as part of this programme have job security on their completion. We agree that there should be further incentives for rural and high needs practices and suggest that accommodation and travel supplements could be considered for RMOs that opt for these placements. While we consider the proposal to develop a new generalised primary-care focussed placement programme to be reasonable as a longer term option, we believe that the development of such a programme is probably not realistic at this point in time.

Additional points on the consultation document

36. Given the proposal to shift from an 80/20 model of teaching delivery to a 50/30/20 spread, we would like clarification about the timing of the Primex which is currently held at the end of the first year. We envisage that this would be pushed back as it would not seem sensible to hold this at a time point when only 50% of the curriculum has been taught. We have previously raised the idea of shifting the Primex to 18 months or even 2 years as part of a suggested longer training programme.

37. If the 6 month training in another vocational scope becomes compulsory in GPEP2 but more doctors are encouraged to enter GPEP training at PGY3, then fewer doctors will have recognition of prior learning (RPL) at the time they enter GP training. This will have implications for DHBs in terms of ensuring there are sufficient appropriate attachments for all GPEP year 2 trainees. We would suggest that the College raise this scenario during their discussions with DHBs.

38. We would like the College to clarify the situation for international medical graduates with GP experience who are currently working under general registration and want to obtain their New Zealand general practice fellowship. Under the proposed changes to the delivery of training, would such doctors have to undertake the whole GPEP training programme? Currently, many such doctors can enter GPEP2 directly and, depending on their previous experience, they may or may not have to sit the Primex.

39. If the College becomes the employer of GP trainees throughout their training programme, the NZMA believes that the College would need to guarantee those trainees on the Voluntary Bonding Scheme (VBS) that their placements will all be in locations that enable them to continue to be eligible for the VBS.

40. We understand that the government is currently funding up to 172 places for GP training but that these places are not currently all filled. For example, this year, there are about 120 GPEP year 1 trainees and last year there were about 150. We would be interested to know where the additional funding that has been set aside for GP training is going, given the discrepancy between funded places and actual trainee numbers.

Summary

41. The NZMA supports measures to bring the current training programme for general practice more closely into line with other vocational training programmes in New Zealand. An essential element of this is increased formal teaching time. Given the complex funding environment, changes to models of training delivery have the potential to impact significantly and differentially on different stakeholders. It is important to ensure that increased quantity of teaching retains the quality of teaching that is delivered. It is difficult to envisage how this can be accomplished with existing levels of funding. Building and sustaining a high quality general practice workforce is central to improving the health of New Zealanders. Many of the proposals in the consultation document could improve the training of the future general practitioner workforce, but only to the extent that they are accompanied by sufficient additional resourcing, both in terms of time and money.

We hope that our feedback on this important consultation has been helpful. The NZMA would be happy to work with the College as this project progresses.

Yours sincerely

Dr Mark Peterson
NZMA Chair