2016 Summary – Community Based Attachments (CBA)

March 2017

The Medical Council New Zealand aims to have all resident doctors complete a CBA as part of their provisional scope of practice by the year 2020. During 2016, NZ RDA contacted all the doctors who performed a community based attachment (CBA) during 2016, for their feedback.

The overall tone of the feedback was positive. Most felt that CBA's enhanced their skills and competency, even for those who were not planning a community based career.

During the winter months, there was a decrease in the number of CBA's that were available. Within the Auckland region, all community based resident doctors were re-deployed to hospital based runs to increase (hospital) staffing levels.

Unfortunately, some CBA practices have revoked the offers of placement for 2017 due to the increased community based workload.

What follows is a breakdown of feedback from all 4 quarters of 2016 (November 2015 – November 2016) by category.

Orientation

Resident doctors reported that they received adequate clinical orientation to the practices they were working in prior to seeing patients. Some doctors had issues regarding the administration requirements around funding and charging patients which we suggest needs to be specifically addressed in orientation as expectations from individual practises vary.

There are ongoing concerns regarding the lack of clarity around organizational logistics - who to apply for leave to, sickness, etc. In most instances the resident doctors defaulted to their RMO Unit manager however coordination between the unit and the practice was not always adequate or timely.

There was definite uncertainty around the point of contact if an RMO was having personal issues within the workplace. Doctors who are performing a CBA are removed from their normal support networks and are at a greater risk of feeling isolated and unsupported.

Whilst we had no specific instances arise during 2016, the general consensus was that the doctor would contact their clinical supervisor, followed by the RMO unit; however this needs to be more clearly outlined in orientation processes and the need for independent sources of support and "go to" people, identified.

Orientation from the hospital, where there was a component of hospital (after hours) practice in the CBA was seriously deficient (see below*).

Infrastructure

Generally, the doctors were provided with appropriate rooms for consultations with patients. The few instances where this was an issue occurred during the start of the year, and were resolved after the first run.

The only ongoing issue is in a Mental Health CBA where there is a proposed loss of the doctor's room which would require them to hot desk and negatively impact on the ability to provide a professional and confidential mental health assessment. NZRDA has objected to this change and awaits the DHBs response.

Clinical Exposure

Doctors on the whole, reported receiving a good exposure to a wide range of problems that were commonly encountered in community medicine. They found this experience valuable as it was totally different to hospital based medicine, provided them with insight in to the process of referral to a hospital including how community-hospital handovers (both ways) might be better managed, and broadened their medical knowledge.

The opportunities to participate in procedural medicine were good.

Doctors who were based in practises with an A+M system felt that this experience was missing exposure to dealing with chronic care patients.

Supervision and support

The level of responsibility that resident doctors received during their CBA created a positive flow-on effect to their practise. Doctors reported that a higher responsibility level was allowed in comparison to House Officer runs in the hospital system. This resulted in an increase in their job satisfaction levels and enhanced their clinical skills such as devising and maintaining ongoing management plans.

It was positive to hear that one CBA practise asked the RMO for feedback and how they could improve to make the experience more valuable for future resident doctors.

When placement occurred in a solo GP environment, there was some confusion around what to do with when the sole GP was on leave. Some doctors were asked not to attend, others were asked to perform "low value" appointments such as routine prescription repeats booked. One house officer was left with the only onsite support being a registrar, and a GP via phone contact.

Although this is preferable to no back-up, it still leaves the house officer feeling potentially isolated and vulnerable, and negatively impacts on their learning experience. If the doctor continues to work "as normal" without the GP present, this also opens them up to unacceptable clinical risk.

Teaching

There was a wide variety of teaching experiences and exposure for resident doctors during the course of year.

Many were provided with dedicated teaching time, which commonly occurred in the form of case based discussions; however, there were some that did not have any specified teaching. Many doctors continued to have access to teaching that was provided by the hospital.

When teaching occurred, the doctors reported:

- an increase in confidence; and
- being better equipped with skills to work more independently; and
- overall improvement in their experience in general.

This has a positive flow on effect to the patient's experience.

The doctors did however express an overall concern at the tension between being used as a service provider and an appropriate teaching and learning environment. This balance they believed whilst not as hard to maintain as in hospital practice still existed and some posed to us whether it would get worse once the "newness" of the CBA system wore off. In their view they felt it would, if left to chance.

Salary category

One of the constant concerns raised with CBA runs is the assigned salary category. Several resident doctors reported attempting to swap into hospital runs as they are more lucrative. However as the year progressed, more reported that they were happy to work reduced hours for reduced pay possibly reflecting the lack of job satisfaction achieved when a hospital component of CBA was included in the run (see below*).

The resident doctors who were required to perform an A+M / after hours (GP) component felt that an increase in salary would have been reflective of the work they were performing and there was one practice where the run description hours didn't correlate to the practise opening hours with the doctor being required to "stay late", initially without compensation.

A run review resolved this however the run description should have accurately reflected the practice opening hours in the first instance, which it did not. In one instance a practice misunderstood the salary system, assuming 50 hours each week had to be worked; this was also easily resolved.

NZRDA is intending to provide some easier to understand information about how our salary system works for CBA recipients shortly, to assist address these issues.

Accommodation

Most resident doctors were able to base themselves at home for their CBA; those who were required to move found the accommodation to be safe, secure and well maintained. In Ashburton, security guards were available to walk them to the accommodation late at night.

Scope of Available CBAs

The predominant provider of CBAs is general practise potentially limiting the desirability to some doctors contemplating a CBA in the future. A variation in the scope and community settings would allow individual doctors more scope to better tailor their CBA experience to suit learning needs and future vocational career pathways. Those that completed a CBA outside of general practise reported valuable and successful experiences to the point that it altered their initial career plans, reinforcing this view.

Hospital shortages

Despite there being CBA positions available, there are DHBs who are persistently requesting RMOs who are allocated to CBAs to swap back in to a hospital based runs, based upon the need to cover roster shortages. The improved salary associated with hospital runs makes this an attractive option. This issue is more common during the winter months, as well as in urban centres.

After hours hospital cover component within a CBA*

There were concerns raised with the level of supervision being provided during the hospital cover component of the run. During long days, doctor's felt as they were just being used as "cover fodder", lacked supervision and also had concerns regarding the lack of continuity of care as they were unable to personally follow up on patients. They felt as if the hospital did not feel any responsibility for them as they were allocated to the community, despite still an employee of the DHB performing work in their hospital. This perception differed from when simply performing ward calls during a hospital based run, where the duties are similar, but the doctor still feels part of the wider hospital team. This may also be exacerbated by the CBA house officer not knowing the wider medical team members who they are working alongside.

This was possibly reinforced by the lack of orientation to the hospital. There were multiple instances of resident doctors new to a DHB being placed on CBA as a first run and being expected to perform long days in the hospital without adequate orientation. Despite reassurances from DHBs that this would be addressed, incidents reoccurred including where doctors were new to a service and expected to perform without any orientation to what was an unfamiliar environment.

The quality of orientation appeared to reflect the adequacy of staffing levels and workloads within hospitals. During the winter months, the quality and ability to offer CBA doctor's adequate orientation appeared to be severely diminished.

Summary

Overall, resident doctors felt this was an extremely valuable and enjoyable experience and potentially the most useful run they have performed. Although, there are some minor issues that need addressing, the number of issues is decreasing with each run that is performed.

Tension over salary and hours worked, plus the drive to deliver service over training is also present in the community system, as it is in hospital, and requires vigilance to ensure the value of training is maintained.

Orientation needs to be improved on a number of fronts and we continue to urge the participants to explore a wider scope of CBA options, especially in the integrated care space.

Whilst the CBA process is enabling a better appreciation of integration of medical practice by the doctors, the same effect is not apparent from some hospitals. Treating the CBA doctors as somehow separate, and not considering their needs as they transition back and forth is both a clinical risk and also a lost opportunity. If the doctors accept a lower salary simply because it is too much hassle, the hospitals will lose a source of afterhours staffing, the ability to bring integration more into the hospital during the CBA will be lost and pressure on salary (e.g. swaps back into hospital based runs) will continue.