RESPONSE OF

THE NEW ZEALAND RESIDENT DOCTORS' ASSOCIATION

to the

Medical Council of NZ's Discussion Paper:

A REVIEW OF PREVOCATIONAL TRAINING REQUIREMENTS FOR DOCTORS IN NEW ZEALAND: STAGE 2

May 2013

Thank you for the opportunity to respond to the most recent proposal. As seems inevitable with responses to proposals of this nature, the focus is on what we disagree with; so first we do wish to acknowledge and thank MCNZ for hearing many of the concerns raised over the previous (July 2011) proposition and reflecting these in this latest proposition. We do however still have concerns which are articulated in the following paper in no particular order.

EXECUTIVE SUMMARY

1. House Officers are not "lost" or in a "hiatus" but adults involved in an apprenticeship based adult learning process, part of a lifelong continuum of learning for doctors. Doctors also value their lives outside of medicine, something that should be recognised and facilitated, and not be subject to another person or person's approval.
2. MCNZ risks both imposing a piecemeal approach to lifelong learning through a limited view of two of the house officer years, and by failing to support adult (as opposed to student orientated) learning processes.
3. Having decided provisional registration shall remain at 12 months, MCNZ must ensure that the proposal enables completion within the year and not provide for "slippage" into a second year.
4. House officers are in an employment relationship; the impacts on and interactions with, must be clearly articulated and planned for to avoid implementation failure. Much greater clarity around audit of runs, allocation impacts, how access to experience will be ensured and community/outpatient experience is required. Collective, effective engagement with DHBs and NZRDA will be required to facilitate implementation.
5. The proposal as a whole and elements within it, lack clear identification of the problem(s) we are trying to solve or improvements we are trying to make. This is required if we are to ensure we have "got it right", for evidence based assessment to be possible and for any cost: benefit analysis to be made.
6. The Whole of Health System must contribute to the essential function of workforce development and maintenance.

Second Year House Officers are not lost.

The suggestion that second (or for that matter third or fourth) year house officers are "lost" is simply wrong.

We find this statement is often made by:

1. those whose recollection of those distant days when "I was a house officer" are shrouded in pink coloured mist and/or have little genuine understanding of the life of a house officer in 2013. Put another way, it is not a phrase you would hear a house officer use of themselves or their colleagues.

2. Those trying to justify action for some ulterior motivation that is less easily articulated, or would be less well received if it were clearly stated.

For what we would truly hope could be the last time, we would appreciate this phrase being stricken from such documents. We would ask that if there is an actual issue underlying the phrase, this be specifically articulated.

The house officer years post 1st year is a period in which doctors have some freedom to experience a variety of medical practise whilst concurrently concentrating on service delivery within New Zealand hospitals (and possibly general practice). This period occurs after six years of intense study at University and a year or more of working through further directed experiences in order to obtain general registration, before the next pressure cooker stage of vocational training.

There is no "hiatus" as MCNZ states as if a hallowed truth in the Executive Summary. At this point doctors are finally free to try some things out, select areas in which they hypothesise they will enjoy. They obtain experience in the area which continues to enhance their skills and experiences. Through this experience, they test their hypothesis regarding whether a speciality is right for them. If their hypothesis was incorrect, they still obtain knowledge and experience.

These doctors appreciate having this time to bed down the practical skills they have gained in their first year as a house officer, test out possible options for their future careers, experience some "life" and offer something back to the New Zealand health system by delivering care to patients. The experiences they gain are crucial to making their decision about the vocational pathway in which they would like to train. They are also crucial to ensuring they make the right decision and whilst doing so, gain more generalist experience in a breadth of settings and clinical contexts.

It is also fair to say that doctors are not seeking more structure during this time. They appreciate the relative flexibility of not being in a formal training programme, however to make the leap to an assertion that this means they are not learning or training is wrong.

They are also adults, capable of making life and death decisions about their patients. We suggest they are equally capable of making career decisions and with it continuing professional development plans. Mentorship and advice is welcomed; however the concept they need to gain "approval" (of their CPD plan) is inconsistent with adult learning and dare we say, paternalistic.

Finally on this topic, resident doctors have a life outside of medicine. Freedom to take time off without gaining approval regarding "appropriateness", freedom to redirect our life plan and career aspirations, must all be accommodated.

NZRDA is concerned that MCNZ exhibits a contradiction in proposing change in a manner that categorises "transition" in a piecemeal fashion, rather than the continuum that a lifelong learning process actually is. Elements of the plan refer to the latter such as recognition of prior learning, but the focus on only two years, when life as a house officer in 2013 is frequently for longer, fails to give true effect to the on-going nature of a doctor's involvement in continuing professional development.

We suspect the two years originally came from the misguided and fortunately now rejected idea, that provisional registration should span two years. Now that we have rejected that proposition, we wonder if MCNZ should not reframe the overall objective here: a lifelong continuum. In the back of our minds remains: and what of the third and fourth years? If the proposal is not structured on a true concept of continuum, won't we simply be here again in a few more years doing the same for the next group of doctors who allegedly need "transition"? In order to do this effectively, NZRDA believes MCNZ needs to change its mind set about who and what house officers are.

Extending provisional registration by stealth.

We applaud MCNZs decision that "the length of the internship will remain at 12 months" but remain concerned about the implementation of this reality. We are concerned that the MCNZ is attempting to extend provisional registration in all but name to 2 years. This is evidenced by:

1. the nomenclature MCNZ insists on using: "internship" applies to first and second year house officers (not just provisional registrants);
2. The failure to state that provisional registration will be gained in 1 year (page 23, point 7 sub section 1);

3. Averaging of attachments over the two years specifically the 12.5% community or outpatient attachments, which are a requirement for provisional registrants in order to gain general registration.

NZRDA believes MCNZ must be true to its correct decision not to extend provisional registration by ensuring all requirements for this one year are stipulated and not merged into the second year or left so vague as to suggest this could be the case.

Within the context of an employment relationship

House officers work within an employment relationship; they are qualified registered medical practitioners. This has a number of impacts that must be considered moving forward, many of which are interrelated:

1. House officers deliver service. The apprentiship model, one all are committed to, requires us to work as we learn. We have had enough time in the academic environment and now learn most effectively when putting our skills into actual practice. If we are of "no use" clinically for want of experience, then sitting watching provides little benefit. The most obvious example is ED where a first year is of limited value to the service and therefore themselves as they effectively get to "sit and watch". GP is another example. General medicine and surgery however are of immense value as we work at a level commensurate with our skills. Anyone who suggests we do not see undifferentiated patients, chronic care conditions and comorbidity in the general medical and surgical setting, has not stepped inside a hospital - at least not recently.

2. The issue of how we will move between in hospital positions to potential external experiences must be resolved. The recent uproar generated by RNZCGP announcing 6 months as a second or third year GPEP trainee must be spent potentially outside the GPEP registrar's on-going employment, will be a whisper compared to the screams that will be heard if the on-going house officer employment relationship is not effectively continued.

3. DHBs, as our employers, have services they need to deliver and employ doctors to do so. It is that service delivery we need to learn. Yes, the pendulum between service and training has tipped too far in favour of service, for SMOs and RMOs. But this has happened as a result of patient demand, not SMOs, RMOs or DHBs' aversion to training.

If we are to realistically shift even a little in the other direction, where are the resources going to come from? We struggle to find 4 hours a week for protected training time; how will we get a further 4 hours for "community experience"?

4. To disrupt the employment relationship, risks disrupting more than the doctors income (as if that is not bad enough) but the complex employment and service delivery processes we have in place to deliver to patients who need us. Run allocations and the manner in which these are managed is simply one example. The more individualised the allocation process, the more work and complexity in delivery. Whilst as a representative of the doctors, we would love to have it all our own way (!) we also know this is simply not possible. There is a balance here of a myriad of complex competing demands which we suspect MCNZ has failed to fully appreciate. The devil will be in the detail: MCNZ must remain open and flexible enough to change the plan on the basis of practicalities where all the parties agree this is reality (as opposed to one party's preference!). MCNZ will need to collectively and effectively partner with NZRDA and the DHBs to work through this process.

5. On a similar theme; how will DHBs manage to organise allocations that fit within a PDP that has to be signed off on an individual basis by someone else who has no responsibility to coordinate overall where everyone is going?

   To demonstrate;

   a. What if all the house officers want the same thing, all of which is signed off? No DHB could accommodate that! And if "practicalities" are going to play a part, will doctor's best interests be protected?
   b. What of timing? Allocations for second year currently start in August when the first years being allocated won't have completed more than 2 first year runs?

   We also sadly note that some CMOs have demonstrated in recent times that they are management first and doctors second; relying on them in this context would pose a conflict of interest.

6. Whilst we are encouraging better primary and secondary integration we also know how hard it is to get the system to shift. 12.5% over the two years equates to 75 actual doctors out of those we graduate, not doing what they do now. That is a lot to organise and consider.

There is no detail on what the 12.5% will represent or how that might be achieved. Until such time as these details are clearer, it is not possible to give effective feedback.

7. MCNZ risk further blurring the lines between performance improvement as an employer's responsibility and that of MCNZ.

Operationalisation

Many of the issues running through our minds under this category lie above but in addition:

1. **Auditing the runs.** We appreciate MCNZ is "proud" of their current audit regime however that covers many less runs than is being suggested, and runs that largely conform to a similar pattern. Then there is the on-going problem of visiting once every five years, and what happens for the remaining four.

   Adding more runs and more variability will require a huge undertaking, that must be robust enough to ensure the runs deliver to objectives without which the house officer could well suffer. What will be the process? Will one house officer that fails to gain their objective trigger an automatic audit? Where is the resource coming from to do this? Is the value in the overall plan worth the investment?

2. **Access.** We appreciate the curriculum is a guide not a tick the box list, but still, how will MCNZ guarantee access? Regional anaesthesia is just one example – in the curriculum but an experience even anaesthetic trainees struggle to get. If the access issue is not resolved, the proposal seriously risks house officers being lost in the middle between MCNZ idealism and DHB practicalities.

3. **Implementation** by November 2014, means pragmatically that all the work needs to be done by August 2014. We doubt that even after this consultation round MCNZ will be in a position to provide sufficient details to NZRDA and the DHBs to enable effective work on what has to be done to enable a smooth transition. We suggest implementation by November 2015 is realistic if it is to be done without the very real risk of implementation failure and all the cynicism and system resistance that would result.

Problem identification followed by evaluation of success

One question NZRDA wishes to pose, is whether the work and resources that will be required in MCNZ's proposal for the second year, will add sufficient benefit over and above what we have now, to be justified. We continue to be concerned that the lack of specificity around the problem we are trying to resolve, leaving subsequent assessment of whether the proposals have been successful almost impossible. In the face of what appears to require significant resources and structural change, we believe that this is simply not justified in our pressure cooker of a health system.

Added value is welcomed and to be strived for, but added value must at least be measured against the added resource cost to achieve it. In the curriculum framework MCNZ talks of the "*use of healthcare resources wisely to achieve the best outcomes*". If the input outstrips the output, is that added value delivering on an essential benefit and therefore worth the cost?

NZRDA is acutely aware that the BPAC scheme introduced in 2012 has added cost to our system. NZRDA does not believe any added value that may have been achieved (and we are not convinced there has been any), was worth it. The fact that the DHBs wore the cost of the MCNZ decision, makes this example particularly pertinent.

If the new proposed system delivers on such a degree of benefit that additional cost is justified, so be it. But how will we measure that and what, having changed the system as radically as is proposed will we do if it is not (justified)? Are we to take this new process on from the basis of on-going adaption as things work or don't?

The "link" with HWNZ

The apparent "link" with HWNZ continues to concern our membership. MCNZ is charged with setting and maintaining standards; and rightfully so as it's primary purpose is the protection of the public. It is vital that our standard setters do that free from political, financial or workforce (shortage) influences.

We are not saying these latter influences are not real or even valid, however if we decide that for the sake of cost the standard will not be reached, then that should be done openly; knowing what the standard should be and what it will be because of X,Y or Z, is simply part of a transparent process in what we hope is still an open society.

HWNZ is a boiling pot of political, financial and of course workforce pressures. It lobbies and influences in its own right; the need to ensure standards also have their champion to ensure all issues are in the mix, is essential.

The "link" and reference to HWNZ as the organisation that "funds prevocational and vocational trainees" is inaccurate and misdirected. HWNZ has some money it uses to fund training, however that money is increasingly being directed at areas of workforce need to stimulate and support, rather than as a general fund.

The focus on HWNZ takes our eye off the role DHBs must play in the funding of their own workforce needs. Any organisation, including health, must fund the development and maintenance of its own workforce as Health does with other employee groups e.g. DHBs fund SMOs $16,000 per head per annum for continuing professional development. If DHBs are to continue to benefit from the service work that RMOs (as registered medical practitioners) provide, as well as future SMOs, then they too must accept there is investment required here.

We also wish to add the "non DHB" sector to this responsibility. If we are to spend more time outside hospitals and if that time is to be spent in "private" sector arrangements, when will that part of our sector shoulder some of the responsibility for workforce development and maintenance? Currently the vast majority of private sector work owes its training to the public sector. NZRDA believes some robust and critical evaluation of costs and benefits is required in this regard and that the private sector including general practice, should be actively engaged in the discussion.

Administration

All jobs have administrative tasks associated with them, and all jobs have work that is less rewarding than other elements. That is the nature of work. In a doctor's life, paperwork is a reality and a requirement of good medical practice. MCNZ recognises this itself in the curriculum framework where it talks of the need for doctors to be competent with electronic record keeping, test and investigation ordering, and completion of other necessary "paperwork" including coronial inquiries and notification of disease.

Just because the system is changing to electronic mechanisms simply means that the "paperwork" is now typing. General statements about low level administrative work being of no value, fails to identify what type of paperwork (electronic or paper based) we are talking about.

- Ordering a CT is a low level administrative task; it is also an absolutely critical one if the patient is to be best served. The doctor ordering the examination must also know why it is indicated and what benefit will be derived for the associated risks (note: the curriculum refers to the house officer understanding the risks of radiation exposure). The visible action may be writing an order; lying behind that is much much more.

- Discharge summaries are another case in point. At the heart of the matter, this is a doctor to doctor communication, a handover; invaluable learning as far as ensuring concise and appropriate communication occurs, essential to good patient care and safety.
- BPAC by contrast has added more electronic paperwork/administration for little if any value.

Locums

What are the safety concerns about locums? Again we suspect MCNZ is responding to the myths and legends of our system and failing to clearly articulate the problem we are trying to solve. RMO locums are most often working in exactly the same role as any other RMO with the on-going supervision requirements any RMO would have. Many, if not most, are simultaneously DHB employees.

We suspect MCNZ is concerned at those who have left DHB employment and are "free agents" locuming in GP or A&M settings. The needs and requirements of this group are quite distinct from the majority continuing in DHB based practice. We encourage MCNZ to identify exactly what their concerns about "locums" are and with it the type of locum, or risk failing to address any actual issues that exist for the want of specificity.

BPAC

What will become of BPAC? As stated above, RMOs are of the firm view that BPAC has added no value but worse still has simply imposed one of those low level administrative burdens MCNZ seeks to remove. NZRDA believes that the curriculum framework should give us the opportunity to have a one stop shop and that BPAC should be discontinued if not before, definitely on the introduction of this proposal.

OTDs / IMGs

NZRDA is of two minds around the distinction between overseas trained doctors of the various categories and NZers. Until we see more of the detail we find ourselves unable to comment further however are mindful of the tension in our current system created by temporary (primarily UK) doctors receiving preference for sought after runs over NZers. The DHBs do this to attract the UK graduates to work here (offering runs that count towards their training in the UK), but in doing so disadvantage and delay NZ doctors in their career pathways and aspirations.

NZRDA believes as a fundamental principle, NZ should focus on delivering to our own population and workforce first, whilst being mindful that visitors also need to achieve and maintain appropriate standards of practice.

PDP

We have already stated above the concerns over structuring a continuing professional development plan in a block of two years rather than a lifelong continuum. We also do not believe the second year PDP should be "signed off" by someone else and believe a significant amount of duplication might exist with our career planning process.

What purpose does "signing off" serve? Are the individuals going to disagree and decide what is right for the doctor? Mentoring and advice would be greatly appreciated, something we already have that available through our career planning processes, so we wonder if MCNZ is not creating more work unnecessarily. We suggest the PDP connect with the career plan around which we already have guidelines (who owns it etc.), guidance and assistance for the doctors etc.

As an aside we make the point that MCNZ should not get into a situation where they deny doctors the same rights all other citizens have in NZ, through the Privacy Act.

Multisource Feedback

We appreciate the concept, but struggle with the realities. As one of our members put it, "this will simply become a popularity contest with RMOs being pulled from pillar to post". Nurses currently often "judge" RMOs on the basis of how responsive to their individual needs they are, ignorant usually of the various pressures and priorities an RMO is juggling at any one time. We have had instances where nurses have given poor feedback on an RMO because they didn't like them and one notorious case where the RMO didn't bring cake to morning tea!

We embrace our teams and without wishing to appear self-congratulatory, do believe RMOs are as a whole excellent team players. However the assessment of that quality through multisource feedback is fraught.

Qualitative versus Quantitative

Why, having moved to a process underpinned by "quality" not "quantity", do we still have to work for 10 weeks per quarter? This suggests MCNZ is not genuinely committed or confident in the proposal as it stands. The 10 weeks is arbitrary. One house officer can encounter an entirely different spectrum of experience to another on any particular run making enforcement of the 10 week parameter always open to challenge. It is also an extremely inflexible and arbitrary parameter. We suggest this be removed.

Community Experience

On the issue of 12.5% "community and outpatient based experience" we simply do not have sufficient information to comment on this further. The duration, setting, opportunity, opertationalisation and what we would actually be doing during this time (the "sit and watch" as opposed to working issue) all need much better definition before we proceed. Having said that NZRDA itself has been involved in encouraging opportunities for better primary and secondary integration over the last 18 months. We are therefore aware of how difficult it is to achieve and believe some incentive is needed. That incentive needs to be delivered in a constructive manner however and we again suggest NZRDA, MCNZ, the DHBs and primary providers need to do a great deal more work on this before we formalise anything further.

Runs

The proposal of no longer requiring specific attachments, primarily in respect to category A runs to be completed in the provisional registration period (proposal 5) will be fraught with difficulty. A question that needs to be asked here is how will the MCNZ ensure that 1st years will be prepared to start night shifts (generally after the first 6 months of work) if they have not completed core runs such as general medicine and surgery? Our collective agreement has specific clauses in relation to this so as to protect RMO's from being placed in unsafe working conditions and equally, safeguard the public. Night shift is one such environment where RMO's need to have the skills to work in a less supported environment.

The view from the MCNZ as expressed during one of the MCNZ's road show's (Christchurch meeting) that it would be up to the RMO to ensure they are competent for the night shift and that if they are not then they should negotiate with their employer as to when they would be is fundamentally flawed. RMO's will be vulnerable to indirect or even direct pressure from their employer to not raise the issue and work anyway.