Medical education and training

Approved February 2013

Background

1. In recent years, a number of changes relating to medical education and training in New Zealand have been implemented or are being considered. Major drivers for these changes have included the shortage of New Zealand-trained doctors and the perceived need to improve alignment between training and the needs of the future workforce. An overview of the current stages and organisations involved in medical education and training are given in Appendix 1.

2. This position paper articulates the NZMA's views on medical education and training. It encompasses a range of aspects ranging from the high level principles that we believe should continue to underpin the basis of future medical education and training. It also includes our views on specific issues that have arisen as a consequence of recently introduced or proposed changes to medical education and training. This paper replaces the NZMA's 2009 position statement on Medical education and training.

Key principles underlying medical education and training

3. It is important to clearly define the role of the doctor when considering medical education and training, particularly given the continued creation of new roles in healthcare.[1] The Consensus Statement on the Role of the Doctor in New Zealand fulfils this requirement.[2]

4. The NZMA encourages the use of sound educational theory in the development and refinement of medical education. We believe that the apprenticeship model of teaching and learning is vital to the success of medical training because of the highly practical nature of medicine, and that efforts should be made to preserve it.

5. The NZMA supports the current basis of medical practice in New Zealand which is that doctors should be generalists first before moving on to specialise in their particular areas.

6. The NZMA supports initiatives that foster a commitment to lifelong learning.

7. While training should be ongoing, it should never be allowed to compromise patient care and quality. However, is crucial to ensure that there is public support for training and acceptance that at times a doctor-in-training will be involved in their care. Employers, doctors and medical organisations need to find ways to ensure that public support is provided.

8. Doctors should publicly support the critical importance of learning and teaching as inherent elements of the practice of medicine. Doctors have an obligation to pass on medical knowledge to ensure that future doctors are available to the community. This is a core tenet of medical professionalism.

[1] See the NZMA position paper 'The Changing Nature of the Medical Team, New Roles and Role Substitution'
[2] See the NZMA position paper 'Consensus Statement on the Role of the Doctor in New Zealand'

9. All doctors have a duty to contribute to the training of other doctors. The NZMA believes that trainers should be reasonably remunerated and allocated sufficient time within their work schedules to provide such training.

The balance between service and training

10. Both service and training are integral to the employment of doctors-in-training. The work environment is also a training environment where interactions with senior colleagues take place, patients are examined and new skills are taught and mastered. As workforce shortages create increasing service demands, doctors-in-training may find themselves unable to gain new knowledge and skills from their experiences as supervision and time pressures are both stretched.

11. The balance between service and training demands in the workplace is generally skewed because in public hospitals – the primary work place for doctors-in-training – service demands are always high. Consequently, formal training is sometimes seen as an 'optional extra' that frequently gets sidelined. However, ongoing education of doctors by doctors is at the core of medical practice and must be supported.

12. The NZMA recognises that some types of medical education and training require commitment outside the work environment – for example, private study, clinical simulation, and course and conference attendance. Whilst some of this will be done in accordance with doctors' commitments to lifelong learning, we encourage employers to recognise the value that these activities add to their employees' practice and to support medical education and training of all types.

13. With respect to service and training, the NZMA believes that:
    - DHBs must be involved in and clearly accountable for training, and must provide resources for medical education at all levels.
    - Dedicated training time must be made available to all doctors in DHBs.
    - Teaching skills need to be taught and funding should be put in place to support this.
    - Workplace teaching should involve both formally structured sessions and opportunistic bedside/ward/clinic teaching, for which adequate support is provided for all medical personnel involved in the provision of training.
    - The investment and purchasing team within Health Workforce New Zealand (HWNZ), previously known as the Clinical Training Agency, needs strong governance from a body with good knowledge of medical education and training, in order to ensure that it funds quality and appropriate programmes.
    - It is essential to achieve a reasonable balance between training and service requirements.

The structure of medical education and training

14. The NZMA recognises that the public hospital system has been - and should continue to be - the cornerstone of medical training in New Zealand. An adequately resourced public hospital system provides a rich and diverse learning experience for medical students and doctors-in-training. The NZMA believes that this environment should be further developed and strengthened over time, and that greater utilisation should be made of the generalist environments offered by peripheral and rural hospitals.

15. The NZMA also believes that there needs to be further consideration of training in other settings and supports the continued expansion of medical training into settings such as general practice, private hospitals, and university departments.

16. Any training planned for new settings should take into account the following principles:
    - Training positions must be accredited by the relevant accrediting authority to ensure that the high quality of training is maintained. Independence between employment and educational supervision should be aimed for. Where conflict between these roles is inevitable, guidelines should be developed to protect doctors-in-training.
    - Private practices must be appropriately resourced to take on a training role and must meet minimum requirements for supervision.
    - Income generated by the activity of a doctor-in-training together with government or other subsidies should fully compensate private practices for any losses incurred by taking on a training role.
    - There must not be any reduction in services at public hospitals as a result of doctors-in-training moving into the private sector. Public teaching hospitals should continue to play the central role in training and should be appropriately resourced.
    - Arrangements for training in private settings must respect patient choice by ensuring that all patients treated by doctors-in-training are informed about the role of trainees in their medical care and freely consent to this.
    - Entitlements and working conditions for doctors-in-training must be protected. This group must not be disadvantaged either financially or in terms of working conditions.
    - Medical indemnity arrangements must not disadvantage or impose extra costs on medical students, doctors-in-training or their supervisors.
    - There must be professional support for supervisors, medical students and doctors-in-training, along with equitable access to educational resources.

Early streaming

17. Medical training in New Zealand is based on the notion of a doctor becoming a generalist first and specialist second. Decreasing the breadth of knowledge of New Zealand medical graduates is not in the long-term interests of New Zealand. Narrowly qualified graduates will not be able to do all the things that we currently expect our graduate doctors to do. Foreseeable flow on effects could include increased inter-specialty referral and increased overall workload. This model is not sustainable for our populations who live outside of major urban centres. The NZMA supports generalist prevocational training.

Part-time and flexible training

18. Medical practitioners enter medical training at different stages of their lives, with different expectations of both their career and of themselves, and most with the ultimate goal of supporting a family as well as a career. Previously (and in some cases presently) many public sector jobs and training programmes were structured in such a way as to make obtaining flexible or part-time roles very difficult.

19. The NZMA supports an increase in the number and variety of flexible, part-time and job-share employment roles available to both male and female practitioners, and considers the

availability of parental leave to medical practitioners as vital - regardless of gender or sexual orientation.

20. Further, the NZMA advocates for greater acceptance of medical practitioners' family roles by specialist medical training programs in order to make the combination of family life and training more manageable, and to improve retention of trainees. In particular, it is necessary to recognise part-time and flexible employment arrangements as being suitable as accrued training time for specialist trainees.

Medical student numbers

21. Training and retention of New Zealand doctors is a priority issue. The Medical Council continues to register slightly over four overseas-trained doctors for every New Zealand medical graduate, each year.[3] In principle, the NZMA believes we should aim for self sufficiency in respect of our medical workforce and supports recent increases in medical student places so long as the quality and accessibility of medical education in New Zealand is maintained and there is a corresponding increase in workforce places for these students to fill post-graduation.

22. Any increase in medical student places must be done in an incremental fashion so as to allow medical schools, district health boards, and training programmes to adapt and minimize bottlenecks. Guarantees need to be made that any extra students will be supported beyond graduation. Employment positions and training posts need to be developed for extra graduates to fill. Colleges need to be consulted with regard to standards as well as capacity to accept increased numbers of vocational trainees because most of our specialist colleges are in fact Australasian Colleges with a head office in Australia.

Ethics and training

23. We refer to clause 53 of the 2008 NZMA Code of Ethics:[4]

    "Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors."

Funding and resourcing

24. Training doctors costs money but is necessary. In simple terms, this means that there must be adequate resourcing for the training institution, for the trainers, and for the trainees to maintain high quality education.

25. Trainers are often senior clinicians of various types. Trainers require sufficient remuneration, time protection and resourcing to provide quality training. HWNZ currently funds part of the training of the medical workforce in DHBs. The mechanisms and requirements for funding training positions continue to evolve. The NZMA believes that DHBs have an obligation to support and train doctors and should be accountable for this function. The NZMA also believes that medical training should become a key performance indicator of DHBs.

[3] Medical Council of New Zealand. Annual Report 2012.
[4] The Code of Ethics is due for revision by May 2013. It is envisaged that this particular clause will be retained.

26. Trainees incur many financial costs of training. Medical students are expected to meet these or borrow. Trainee interns are supported by Vote Education with the trainee intern grant, which recognises these costs. For doctors in training, many costs of training are currently reimbursed by DHBs as part of the employment contract of resident doctors.

27. The NZMA supports the minimisation of financial costs to medical trainees at all levels. High levels of student debt encourages doctors in training to leave to work overseas and encourages doctors in training to choose their vocation based wholly or primarily on financial imperatives. Financial barriers are particularly significant to those from lower socio economic groups, as well as Maori and Pacific students.

28. The NZMA supports the continuation of interest free student loans for medical students and the "voluntary bonding" scheme for incentive-based debt relief to doctors working in hard-to-staff locations and specialties.

Prevocational training

29. HWNZ and the Medical Council are in the process of reviewing prevocational training and registration requirements. Among the proposals that are being considered include the development of a New Zealand curriculum framework, an e-portfolio (record of learning), and an assessment model that forms the basis of a professional development plan.

30. The NZMA believes that a national curriculum should focus on increasing the amount of supervised clinical time and reducing the amount of time spent on paperwork and trolley pushing. We agree that an element of competency-based training being added to the pre-vocational years would be of great benefit, however, we do not want to see such an increase occur to the detriment of the apprenticeship model which underlies the training of doctors in New Zealand. Teaching skills should also be included in the curriculum to ensure that doctors-in-training are competent as teachers.

Appendix 1 – Overview of the stages and organisations involved in medical education and training in New Zealand

There are two medical schools in New Zealand, at Auckland University and the University of Otago, which has campuses for medical training in Dunedin, Christchurch and Wellington. The government has recently increased student numbers in both schools. There are placements for undergraduate students in all major hospitals and increasingly in provincial and rural hospitals. General practices throughout the country are also involved in undergraduate experience and teaching. Both medical schools have established rural programmes.

Prevocational training in the PGY1 or probationary registration year is managed by the DHBs who are accredited by the Medical Council to provide an adequate supervision and training experience. The Medical Council is in the process of reviewing prevocational training, including during PGY2. The investment and purchasing team within Health Workforce New Zealand (HWNZ), previously known as the Clinical Training Agency, currently funds part of the training of the medical workforce in DHBs.

Health Workforce New Zealand has also collaborated with DHBs, education providers and professional associations to establish four regional training hubs to support effective health professional training. The role of the hubs include standardising training and education programmes, co-ordinating clinical placements to support vocational training programmes, supporting trainees to develop and implement career plans, and the provision of mentoring services.

Vocational (specialist) training is primarily the responsibility of the medical colleges in association with the employers and, in some cases, the universities. The training programmes are set and supervised by the specialist colleges, and purchased from the health providers through HWNZ. Specialist qualifications in New Zealand are Fellowships of the specialist colleges, gained after meeting their training and examination requirements.

All doctors in New Zealand must participate in ongoing education in order to gain their practising certificate. The Medical Council accredits the CPD programmes of the colleges and audits compliance by doctors.