

Foundations of Excellence
Building Infrastructure for Medical Education and Training

Report of the Medical Training Board

August 2009

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Notes on Terminology

There are a number of different terms used to describe doctors between the completion of medical school and the attainment of vocational registration. In this report, the Medical Training Board refers predominantly to ‘doctors-in-training, meaning doctors who have graduated from medical school and who are in training toward vocational registration.

There are two distinct groups:

- *prevocational doctors-in-training*, who gain their training through being in clinical placements but have not yet entered a vocational training programme
- *vocational doctors-in-training* or training registrars, who have been accepted into specialty training.

Note that the terms house officer, house surgeon, registrar and resident medical officer (RMO) refer to employment roles which do not always align with training definitions of prevocational and vocational doctors-in-training.

Table A1: A simplistic depiction of the training and employment pathways

Training pathway	Medical student – early learning	Medical student – advanced learning	Trainee intern ¹	Doctor-in-training		Vocational registration
				Prevocational training	Vocational training	
Employment pathway	Undergraduate/ medical student			House officer / house surgeon	Registrar	Consultant / specialist
				Resident medical officer (RMO)		Senior medical officer (SMO)

This table does not include other doctors *not* in formal training such as:

- *medical officers* (formally known as medical officers of special scale, or MOSS), who are usually doctors at registrar level who have either not entered vocational training or have opted out of vocational training before completing a particular training programme
- *locums*, who may be at any level in the pathway, and who are employed on (usually) short-term contracts to fill vacancies in permanent staff posts
- *non-training registrars*: while the use of the term ‘registrar’ usually applies to doctors on a vocational training programme, the filling of a registrar job is not contingent on the doctor being registered on a particular vocational training programme. Currently the number of registrar jobs exceeds the number of registrar training places across the various vocational programmes, so there are a number of so-called ‘non-training’ registrar posts.

A selected list of terms used in the report is provided in Appendix 2.

¹ Note, some definitions include trainee interns as ‘doctors-in-training’.

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Executive Summary

In September 2008 the Medical Training Board (MTB) released a series of documents² on the medical workforce and on the need to achieve integration and coordination in medical education and training. This report takes into account the feedback received on these documents and progresses the work to the next level. It focuses on what change is needed and how it could occur, and proposes a framework for the structure and governance of an integrated medical training system that builds on current arrangements.

In consultation, there was considerable support from the sector for an integrated education and training framework. The need for a smooth medical training continuum was recognised, especially covering the period between graduating from medical school and entering vocational training. As a result, although this report focuses primarily on the prevocational³ period, it also addresses ways to improve the coordination of education and training across the whole continuum.

The MTB concludes that:

- the health care system needs greater integration of medical education and training across the continuum of learning, from entry to medical school to completion of vocational training, with a supportive structure that allows for flexibility to recognise the variety of ways that doctors move through the learning process
- the current systems of apprentice training and experiential learning for doctors-in-training need enhancing by consistent management with oversight of the educational aspects of clinical placements
- improvements in accountability for, and monitoring of, funding relating to postgraduate education and training funding are needed.

Recommendation

The MTB therefore makes the following recommendation:

- that a new body is established with the capacity to coordinate medical education and training across the entire continuum of learning and govern the transition from the current system. The new body would be called Medical Education and Training New Zealand (METNZ) and would replace the MTB.

METNZ would report to the Minister of Health, and either absorb the medically related areas of the Clinical Training Agency (CTA) or have the authority to closely oversee the medical training component of CTA's current work to optimise contracts with training providers.

METNZ will lead work to:

- increase support for clinical teachers, including incentivising quality training
- increase the range of training institutions⁴ that are able to be involved in training doctors
- ensure system-wide integration of education and training
- develop a national information system for medical education and training

² Medical Training Board 2008a, 2008b, 2008c.

³ Prevocational years are the time following the doctor's formal education in medical school to when they enter vocational training.

⁴ In this report 'training institution' refers to DHBs and all other possible service delivery areas where the training of a doctor could take place, including general practices, private hospitals and community settings.

- enhance links with other sector groups including the Medical Council of New Zealand (Medical Council), medical colleges, district health boards (DHBs), medical schools and professional groups
- develop nationally consistent modules of learning
- facilitate national workforce planning that allows for flexibility and provides a long-term view
- develop a new competency-based framework for the prevocational years building on existing work being achieved in the sector with any changes to be implemented only once a suitable structure and governance regime is in place.

METNZ will also:

- build on and strengthen the current development of four networks of DHBs across the country
- provide a basis for coordination in other areas of postgraduate education and training, including nursing, midwifery and allied health
- complement the work of the Ministerial Task Group on Postgraduate Education and Training and the Resident Medical Officers (RMO) and Senior Medical Officers (SMO) Commissions⁵
- be informed by other activity in the sector, such as the work being done by DHBs and District Health Boards New Zealand (DHBNZ) on the roles of health professionals.

As well as the proposals for METNZ, this report discusses:

- the possibility of a single employer for all doctors-in-training
- the need to ensure training capacity is relevant for health needs in the specialty areas required to service the future New Zealand population.

The Government has already made a commitment to invest in the medical workforce through the creation of a substantial number of new medical school places for doctors over the next few years. This investment needs to now flow on to prevocational and vocational training otherwise the benefits expected from the original investment will not be realised.

Due to the complexity of the system there is no 'quick fix'. This report identifies a pathway forward.

The MTB is advocating an evolutionary approach to change, building on the best parts of the current educational and training system to ensure that New Zealand has the right doctors, serving in the right places, at the right time, with the right skills.

The report is set out in six sections.

- **Section 1** covers the background to the paper and the current organisation of medical education and training in New Zealand.
- **Section 2** looks at the pressures for change.
- **Section 3** discusses the proposed changes.

⁵ See Appendix 2 for definitions of these terms.

- **Sections 4 and 5** outline the infrastructure that would enable the changes to take place and how this infrastructure would link with current bodies working in education and training in New Zealand.
- **Section 6** considers the way forward, outlines the need for a thorough costing and gives an initial implementation plan.

The appendices provide further information on the links between current and proposed structures, and more detail on the proposed roles.

Section 1: Introduction

You need to train your workforce for the future not the past. That workforce needs to master a whole new set of skills relevant to the leadership of, and citizenship in, the improvement of the health care system – patient safety, continual improvement, team work, measurement and patient centred care to name a few. (Don Berwick)⁶

This report outlines how a co-ordinated national approach would give better outcomes for doctors-in-training and therefore better health outcomes for New Zealanders.

1.1 Background

In the discussion paper *The Future of the Medical Workforce* (Medical Training Board 2008a) the Medical Training Board (MTB) reviewed the issues relating to the current medical workforce and changes likely in the health sector in the future, and proposed that New Zealand needed to train more doctors. This led the MTB to review how medical education and training operate in New Zealand, what changes are needed to cope with any increase in the number of doctors to be trained, and how to improve that training.

The focus of the MTB's discussion document *Integrated and Coordinated Medical Training* (Medical Training Board 2008b) was the continuum of learning and the need to develop an educational framework with outcomes, assessment and a curriculum for the prevocational or 'transition' years – the time following doctors' formal education in medical school until they enter vocational training. The issue being how to ensure this time is best used in the needs of both the individual doctors and the health system as a whole.

In *The Curriculum Framework* (Medical Training Board 2008c), incorporating the *New Zealand Education Framework for Prevocational Training*, the MTB, working with the Medical Council of New Zealand (Medical Council), set out a possible framework that could be used to ensure a match between desired outcomes and assessments for the prevocational years.

In September 2008 all of these discussion documents were placed on the MTB website⁷ and circulated through the sector with feedback requested. The papers were also discussed at forums held throughout New Zealand in November and December 2008. Members of the MTB have also raised the issues at many other forums. By January 2009, 30 submissions had been received. A summary of the responses to these papers is provided in Appendix 1.

The key themes from the responses included:

- general agreement with a nationally coordinated approach
- general agreement with a curriculum framework
- concerns about the application of 'waypoints' and the possibility of a 'tick box' assessment approach
- concerns about some of the implementation aspects of the curriculum and the years to be spent at each stage of education and training
- the need to build on successful parts of the current system.

⁶ President and CEO of the Institute for Healthcare Improvement, USA.

⁷ www.moh.govt.nz/medicaltrainingboard

The MTB, mindful of this feedback, has concluded that change should be evolutionary, within a strong organisational and governance framework.

As a result, this report shifts the emphasis from specific competencies and assessment processes for prevocational training to the infrastructure necessary for delivering any recommended system.

This report looks at how to better coordinate and integrate prevocational education and training so that the doctor-in-training is able to move confidently from the medical school environment, gain experience and effective training in the prevocational years, and then move into vocational training. The report sets out the rationale and structure of a nationally based medical education and training body which would enable good models to develop and drive system-wide change.

1.2 Summary of the current training processes

The MTB endorses the need for all doctors to be involved in lifelong training and education as a commitment to maintaining competence to practise, whether or not they are in formal training.

A lifelong commitment to training and education includes ensuring doctors maintain their competence and meet requirements for recertification. However, at certain stages of their career doctors are required to concentrate on education and training to reach a particular career milestone.

During the five years of learning following entry to the medical programmes at Auckland and Otago universities there is a strong emphasis on patient-centred learning and the development of clinical and professional skills. The curriculum provided by the medical schools requires regular accreditation by the Medical Council in partnership with the Australian Medical Council (AMC). There is formal exposure to the work environment at many points during the medical student curriculum – in primary care, rural and regional environments, and in secondary and tertiary hospitals. This learning culminates in the final year in medical school, known as the trainee intern year. This is a year of closely supervised clinical experience, with an emphasis on increasing responsibility for patient care.

On graduation from medical school the doctor then takes part in further education and training (primarily via the apprenticeship model) by working in a series of (usually) three-month clinical placements⁸ in district health board (DHB) hospitals or, in a limited way, in general practices. The clinical placement should give an overall educational experience and enable the doctors-in-training to have access to seniors who give supervision, assessment and feedback. To ensure placements are suitable for this purpose, the Medical Council accredits hospitals for training and requires clinical placements to meet certain criteria.⁹ As well as accrediting hospitals and clinical placements, the Medical Council also contracts intern supervisors from each DHB to

⁸ The term 'clinical placement' is used to describe the placement of a doctor-in-training in an area of the hospital for apprentice training. Clinical placements are also sometimes called 'allocations', 'runs' or 'rotations'. Currently the PGY1 doctor (see footnote 10) must experience at least four specific clinical placements. In vocational training the training registrar works in training 'posts' within a specific specialty.

⁹ The Medical Council assesses runs into categories A, B, C and D based on the overall educational experience, development of objectives, and adequacy of supervision, assessment and feedback. To gain general registration, a prevocational doctor has to complete four clinical placements with at least one in an A medical category, and one in an A surgical category, in a hospital accredited by the Medical Council.

assist in the assessment and monitoring of doctors-in-training and to help develop an educational programme in this first post-graduation year (often called PGY1).¹⁰

In the second year post-graduation (PGY2), doctors are still involved in learning, but specific training in this period has never been well defined. This lack of definition has led to much criticism in recent times as it is often when doctors move into locum work or leave New Zealand to work overseas. This is highlighted by the fact that although we would expect about 340 doctors in this year (based on numbers exiting medical school) just 168 are currently identified in the system. Despite the lack of definition however, it is also when doctors have an opportunity to consolidate skills and gain more general work experience, decide on career choices, and take a break from years of study before entering vocational training. Many doctors at this stage of their career expressed satisfaction with the flexibility it offered. Complicating calls for changes to this year is that currently all vocational training programmes require a minimum of two post-graduate years prior to entry.

Once doctors enter vocational (specialist) training¹¹ they work in 'training posts', which are assessed by the relevant specialty medical college or vocational branch. These programmes usually take between four and seven years. Similar systems operate across most of the colleges and vocational branches, and currently the bulk of this training occurs in DHB hospitals.

¹⁰ 'PGY1', or 'post-graduate year one', refers to a doctor-in-training in their first year after graduation. These doctors are expected to be supervised, complete a number of specific runs and attend formal education sessions. The Medical Council also puts restrictions on matters such as when the doctor may work nights or in emergency departments.

¹¹ Training in vocational areas is organised via the professional colleges and vocational branches, who set standards for the programmes, accredit training posts and approve supervisors. A vocational branch is a specialist college, society or association accredited by the Medical Council. It usually delivers vocational training, and a doctor who has completed this training successfully gains vocational registration. Most vocational branches are related to colleges, the exceptions being accident and medical practice (AMP), family planning and musculoskeletal medicine.

Section 2: Pressures for Change

I can't change the direction of the wind, but I can adjust my sails to always reach my destination.
(James Dean)

The current 'apprentice' system is under a great deal of pressure. It can no longer be relied upon to provide consistent and acceptable training and education for every doctor in the system.

2.1 Why is change needed?

Some responses to the MTB documents released in late 2008 noted that New Zealand produces doctors who are well respected overseas and who fit well into the New Zealand health system, so there is no real need for change.

The MTB, in its discussion paper *Integrated and Coordinated Medical Training* (Medical Training Board 2008b) noted that if an educational and training framework is to optimally deliver the next generation of medical professionals it must:

- “recognise the critical importance of sustained and continued availability of care and treatment for patients
- provide a defined series of experiences where consultants, trainees and patients overlap
- ensure a commonality in training obligations across trainers
- optimise relevant clinical experience through rotation and opportunistic placement in situations of high interaction
- manage engagement in activity unrelated to expanding or affirming clinical competence
- share training with other health professionals, where appropriate and educationally beneficial
- ensure that education and training is delivered across all domains of health care delivery: tertiary hospitals, secondary hospitals, regional base hospitals, community health settings and general practice, private health providers, non-government organisations, and overseas”.

In general, respondents to the MTB discussion paper stated that the current system delivers on most of these issues, but agreed that deficiencies do exist.

The Workforce Taskforce (Workforce Taskforce 2007) also identified the following key issues that need urgent attention in the area of the education and training of doctors.

- “The quality and relevance of medical education and training could be improved by greater continuity between undergraduate medical education and subsequent clinical training and increased responsiveness of the whole system to the needs of the health sector.
- The health sector is complex, and there are many players involved in educating and training medical practitioners – there is a need for a central body to coordinate and oversee medical education and training.
- The difficulties for training in clinical settings created by the inherent tension between service delivery and training needs, the changing service delivery patterns in public hospitals and the implications of industrial agreements over the last 20 years, are putting pressure on the current apprenticeship model.”

The Workforce Taskforce also noted, anecdotally, that there were reduced opportunities for doctors-in-training to receive training and education because service commitments often prevent their participation.

Feedback from the sector and successive reports on medical education and training have confirmed that while the 'apprenticeship model' is still the most appropriate format for training doctors, most recognise that service delivery today has changed significantly, in that:

- the level of acuity of hospital inpatients has increased
- the average length of hospital stay has decreased
- there is greater delivery of health care in the community and primary care sector
- demographic changes have increased the demand for, and changed the nature of, health services
- the contribution of technology and pharmaceuticals has increased the capacity of health services to meet needs, and innovate, but this has increased the need for continual learning
- working hours and conditions have changed, with an increased focus on service delivery, creating the loss of continuity of care and a diminished importance placed on education and training
- there are changes occurring in college and vocational branch requirements, undergraduate education and community experience
- some treatments are now only provided by the private sector
- there are changes occurring in traditional health care roles with the evolution of health care teams
- New Zealand has to compete in the global market for health practitioners
- there are changes in the availability and delivery of clinical information.

At a pre-vocational level, respondents to the MTB discussion documents noted that doctors-in-training are often not being provided with some necessary skills and it is increasingly apparent that apprentice style learning is no longer able to provide a consistent experience across the country (eg, the Royal New Zealand College of General Practitioners (RNZCGP) noted that some doctors-in-training are no longer proficient in basic examinations, such as examination of the knee or the taking of cervical smears).

In vocational training programmes, it is recognised that a lack of coordination makes transferring between programmes difficult and that the development of common modules of training would allow for greater flexibility.

The MTB wishes to work in partnership with the colleges and vocational branches on these matters.

Overall, most respondents agreed with the conclusions of the reports that there is a need to improve the current system.

2.2 What needs to be addressed by any new system?

Respondents noted that an improved educational system should address:

- the need to ensure that training and teaching are seen as an integral component of service delivery and employment throughout the health system
- recognition of the tensions between service delivery and training needs in the DHBs, and the lack of 'drivers' for the DHBs to be more innovative in relation to the delivery of training

- the need to adapt the training systems so that they can cope with changing patterns of care within hospitals
- the need to look at alternate providers of training, including general practice and private hospitals
- the need to identify what degree of consistency is necessary, and then develop a structure to achieve this on a system-wide basis
- the need to find ways to improve governance, leadership and *real* accountability across the whole training system
- the need to develop a coordinated approach to medical education and training which spans the lifetime of a doctor, from student to specialist, and ensures that at each stage there is cohesion in the transition from the previous stage.

Respondents also indicated that any changes in the education and training of doctors must address some of the shortcomings of the current systems, such as providing:

- access to meaningful patient contact
- exposure to a wide range of patients and specialties
- adequate supervision
- learning in a range of settings, with both experiential learning and competency-based learning
- wide generalist training, including greater exposure to general practice and primary care.
- greater support and time for trainers.

We need a system in which doctors-in-training want to stay in New Zealand to train and senior doctors want to stay in New Zealand to teach them.

A coordinated training system must be an integral part of our health care system in order to achieve a sustainable workforce. In addition, any new system needs to articulate with Australia due to the strong trans-Tasman Medical Council and college linkages.

2.3 Why do changes have to be considered now?

Pressure on clinical placements is already increasing. Without central coordination, this pressure, and the consequent variation of training experiences, is only going to get worse.

2.3.1 Increasing numbers of doctors-in-training

The number of medical students entering training was increased by 40 in 2004, a further 40 in 2008 and will increase by another 60 from 2010. Further increases are likely from 2011. These increases will lead to growing pressure on already strained systems for pre-vocational training. Change is needed now to ensure that the medical training system can cope with this large increase in doctors-in-training.

The increasing number of medical graduates will also flow through to vocational training. This creates further challenges as currently there is no centralised way to ensure New Zealand trains the mix of specialists it needs.

2.3.2 Changes in the health services

In the next few years, alongside the increase in the number of medical students, there will be significant changes in the delivery of health services due to:

- difficulty in forecasting shifts in demand for medical services
- continuing demographic changes in New Zealand society
- epidemiological shifts, necessitating a greater emphasis on the prevention and treatment of chronic conditions
- innovations in the delivery of health care
- changing programmes in colleges, where there is a move to competency-based training and assessment processes – these changes are developing independently and without cross-college and vocational branch coordination.

Overall, the pace of innovation will accelerate, and these changes will have an impact on:

- the roles of health professionals
- the way services are provided
- the scope and nature of primary care and general practice.

If there were a coordinated national approach focused on improvement in the way medical education and training are organised, the benefits of the expected changes could have a greater impact.

2.3.3 Need for coordination in medical education and training

Post-graduate medical training is currently spread across 21 DHBs and more than 30 vocational or specialty areas, and neither the Medical Council nor the professional colleges and vocational branches have the authority – or capacity – for other than a loose coordination of training. This variation is exacerbated by differences in the focus of change, its pace, and how training fits with other initiatives occurring throughout the health system.

DHBs, as the main prevocational training institutions, will require further significant investment in training as the numbers of doctors to train increases. Part of this investment will need to be an increase in the number of, and support for, those involved in training, most notably senior medical officers (SMOs).

Over the past two years there has been a significant investment across DHBs in job sizing (ensuring the right number of SMOs to deliver services), as well as an increase in non-clinical time of up to 30 percent of employed time (to allow for teaching, quality improvement activities and audit, among other activities), negotiated as part of the senior doctors collective agreement. Some DHBs have also created Directors of Clinical Training. Unfortunately, this investment has not been coordinated across DHBs and the extent of its implementation is variable. Although in a number of areas and across many services the changes have resulted in improved quality, the impact of this investment on non-clinical activity has not been fully utilised. Part of this investment could be better directed into creating an increased focus on teaching. Despite this investment, some submitters report a sense of disengagement from training among SMOs, highlighting further the need for change.

In order to better utilise these changes, national and regional coordination is needed.

2.3.4 'No change' is not a viable option

The MTB has significant concerns that the present system of training doctors is unlikely to adjust effectively as the demands on it increase. The large number of bodies, operating in isolation to deliver education and training to doctors, makes it impossible for any part of the system to have sufficient influence to ensure a managed interaction between medical training and the other critical points of change in the health service.

It has been argued that change would occur if the current accreditation and contractual systems were used to 'force' the service providers, such as DHBs, to make positive changes to education and training. While this is partly true, it would still not provide the fundamental requirements for coordination, consistency of approach, national planning and continuity of learning, nor would it increase the support and motivation of teachers to teach, or solve the pressure on the number of clinical placements.

It is clear that the recent and heralded increases in medical school numbers have been a long-delayed but necessary response to the major imbalance between the supply of New Zealand-trained doctors and the demands New Zealanders have for health services. Along with a growth in short-term appointments to SMO positions, there has been a significant growth in the creation of placements for doctors-in-training. These posts, while nominally about training, have tended to be created in response to service demands resulting in varying training experiences. Increasingly, these doctor-in-training posts are filled by doctors who are not planning to continue their training and complete a vocational training programme through a New Zealand college or vocational branch.

Without any nationwide oversight of the existing ad hoc and fragmented arrangements, there will be increasing pressure to employ more doctors-in-training so that health services are available, but where the clinical placements will have few if any training benefits. By filling up clinical placements in this way, the system is at risk of decreasing the quality of clinical placements even further as the increasing number of students, trainee interns and doctors-in-training all try to gain meaningful patient and SMO contact.

In the last half of the next decade, when twice the current number of New Zealand medical graduates is expected to be entering vocational training, the sector needs to have developed the means to effectively match the number of clinical training placements to the number of medical school graduates.

There will also be challenges due to the development of new vocational training positions in New Zealand by the Australasian and New Zealand colleges as the number of Australian medical graduates seeking vocational training doubles due to medical school increases on the other side of the Tasman.

2.3.5 Building on current investments

Large investments are already being made through the Government's commitment to increase the number of places in medical schools. This increase needs to be built on so that doctors leaving medical school can gain satisfactory training and experiences in their prevocational years and have appropriate opportunities for vocational training. If further investment in prevocational and vocational training does not occur there is the risk that doctors-in-training will continue to leave New Zealand for better training experiences elsewhere.

2.4 An integrated system

As the MTB's report, *Integrated and Coordinated Medical Training* (Medical Training Board 2008b), noted, an integrated system would:

- produce a stable, predictable stream of trained specialists
- give the critical mass of medical specialists required by each field of medical practice
- provide local and national balance between the numbers of trainees and trainers
- give an appropriate balance between junior and senior doctors-in-training, where numbers are decided by the overall needs of the system rather than as a reaction to acute issues
- provide a nationally coordinated and standardised approach, minimising the inconsistencies of the current system
- increase the integration of training across public, private, primary and community delivery of health services
- ensure the processes of training support the delivery of high-quality care
- protect trainees in their training role, provide access to valuable learning activities and develop incentives for innovations in service delivery so that there is less dependence on trainee service provision
- value excellence in trainees and trainers
- recognise, reward and support SMOs, teachers in general practice and all health professionals who are involved in training
- build on regional groupings of DHBs by organising education and training in a regionally coordinated way
- provide incentives to service providers to create and support educational opportunities for doctors-in-training that aspire to excellence in service delivery, provide quality training and meet national needs
- increase accountability of the expenditure of government-funded training money
- have some clear, widely recognised processes of accountability for governance and management roles
- be consistent, and integrated, with other publicly funded areas of health education and training such as nursing, midwifery and pharmacy.

All of this would require a national, systematic, integrated and collaborative approach that recognises the uniqueness of New Zealand's health needs and the importance of linking workforce training to them.

2.5 Learning from experience

In the United Kingdom (UK) the institution of the Modernising Medical Careers (MMC) programme, with the accompanying changes to prevocational training and entry to specialist training, has been criticised for the way it was managed and the lack of engagement with those affected by the changes. The deficiencies in the MMC were highlighted in the report *Aspiring to Excellence: Final report of the Independent Inquiry into Modernising Medical Careers led by Professor Sir John Tooke* (Modernising Medical Careers Inquiry 2008). These included the:

- lack of meaningful consultation with the profession
- lack of funding and incentivisation for those delivering education and training
- failure to ensure that changes in the structure of postgraduate training were guided by clear principles that embraced a broad base in the early years, flexibility and the pursuit of excellence

- need for workforce planning to account for the impact of changing patterns of health care on future medical workforce size and structure.

The review also noted:

- a lack of clear policy objectives
- wide-ranging misconceptions about the educational and workforce objectives of the MMC
- an emphasis on competency-based training, which did not give adequate consideration to workforce and service implications
- failings of the computerised matching system
- misjudgement of the number of placements required for entry to specialty training places
- the lack of links with the undergraduate curriculum, and a perpetuation of the student role with 'tick box' assessment systems.

Despite these concerns, it was also noted that for the first time the Foundation Programme years comprised a formal programme with a national curriculum and structured assessment of clinical competencies. Many consider the changes were necessary and that the overall outcome will improve medical education systems. Overall, the review of the UK experience contains a number of important lessons for any change process adopted in New Zealand.

In Australia the pressure on clinical placements is increasing after the large increase in medical school places over recent years. Innovative training solutions applied in New Zealand may attract some of those doctors to this country and should keep more New Zealand-trained doctors here.

Learning from overseas experience, the MTB is recommending evolutionary change, in partnership with key stakeholders, to develop strong governance arrangements and a clear, well-articulated vision.

2.6 Summary of need for change

Between 2004 and 2015, the number of medical school entrants will double, with a sharp increase in the number of doctors entering prevocational and vocational training. Unless coordination takes place across the sector, local investment in training is likely to be inadequate.

A change is needed in the governance process of education and training so that the benefits of a coordinated approach can be managed. These governance processes need to focus on improvements in the medical education and training pathway throughout New Zealand as a whole. Such governance will help establish agreement on the direction of change and develop coherent expectations among trainees, trainers, and institutions.

Section 3: A Proposal for Change

Become a student of change. It is the only thing that will remain constant. (Antony D'Angelo)¹²

3.1 Education and training in the prevocational years

To enhance education and training in the prevocational years, clear policy objectives are needed so that all involved – especially the doctors-in-training themselves – are clear on the desired outcomes.

Following discussion and consultation feedback, the MTB proposes the following key policy objectives:

- doctors, once trained, will be 'fit for practice'; that is, able to deliver high-quality patient care in a range of settings that meet the current and future health needs of New Zealanders
- all doctors in New Zealand will have a broad, generally-based training
- all doctors will be given comparable opportunities to learn, and may eventually be assessed through the development of a national framework and assessment system
- doctors-in-training will have exposure to different forms of training, including apprentice learning, skill laboratories and online learning, in order to meet their personal learning objectives. In future they may keep a record of their learning via a portfolio
- the training will be primarily experience-based, achieving competence across the domains of clinical care, communication and professionalism
- there will be sufficient clinical placements in the prevocational years to enable all those who graduate from medical school in New Zealand to meet the requirements for general registration within 12 months, and eventually to be able to enter specialty training (where the number of specialists in training will be based on the predicted needs of the population)
- the training pathway will allow doctors-in-training to meet the requirements of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and the Medical Council
- the system will prepare the doctor to be able to identify and be responsible for their own training needs, and to accept and be involved in peer assessment so that they are able to monitor their own and others' performance and competence throughout their career
- the training framework will link to medical education systems in Australia and possibly the UK to acknowledge the educational value of overseas experience
- all training systems will treat patients and carers with dignity, and will deliver the skills and competencies required. Assessment systems will be robust, transparent and fair; and the systems will operate within the requirements of the regulatory framework in New Zealand, including equal employment opportunities, human rights principles and safe working hours.

¹² Antony D'Angelo is the Chief Visionary Officer of Collegiate EmPowerment, where it is his lifetime mission to 'Take higher education deeper'.

3.1.1 Generalist training

All doctors in New Zealand need to acquire a set of general core competencies before entering a vocational training programme. It is these competencies and skills that must be incorporated into any future national curriculum framework.

There was general agreement amongst respondents of the need for all doctors in New Zealand to acquire a set of general core competencies before entering a vocational training programme.

The system needs to improve the quality of the doctor-in-training experience, especially in tertiary hospitals, where doctors-in-training are often overloaded with administrative tasks. If there were greater incentives and some competition among training institutions to provide better clinical placements, greater flexibility in the content and length of placements, and a greater variety of settings in which placements can operate, there should be enough high-quality placements to give the doctors-in-training the generalist experience they require.

Under a new, more flexible system, doctors-in-training would be able to apply for a clinical placement that meets their training needs at a given point in time. In addition, the length of available clinical placements should not be limited to the current three-month exposure in one particular area, but should allow flexibility in length to best meet the needs of trainees and the diverse needs of different service providers.

In future, a clinical placement may incorporate work in more than one setting and more than one type of care, exposing the doctor-in-training to more experiences and assisting with long-term career choices. Once a doctor-in-training has decided his/her long-term career objectives, clinical placements that prepare them for that type of vocational training would be emphasised.

To gain the generalist skills a doctor-in-training requires, he or she would be encouraged to complete a period (but not necessarily a full clinical placement) in each of the following settings.

- **Primary care** – Working in general practice and other primary care services gives exposure to working within a multidisciplinary team for the management of a range of conditions such as chronic disease, undifferentiated illness, preventative care, and pre or post hospital care. While it has been argued that exposure to primary care is less relevant to doctors-in-training wanting to pursue other specialties, it is useful for all doctors to be exposed to primary care to forge better links and smooth the referral interface between primary, secondary and tertiary care later in their careers.

For some doctors-in-training this exposure could be one day a week over a period of weeks or months, or attendance at specific clinics, rather than a full clinical placement. This could be negotiated by the DHB as a training institution wishing to enhance the experience of its doctors-in-training. Primary care can also offer opportunities to work in other settings, such as in marae-based health services or with migrant communities.

- **Secondary hospitals** – This would ideally be in a secondary hospital linked to the prime placement of the doctor-in-training (eg, combining Hutt and Masterton) to reduce dislocation in the doctor-in-training's home life, and could, for example, be for one day a week for three to six months instead of a period of three consecutive months.
- **Emergency medicine** – Consideration should be given to whether some of this training could be done in an AMP clinic instead of in emergency departments.

The doctors-in-training would also be encouraged to do clinical placements in:

- tertiary hospitals, where they would be exposed to a wider group of sub-specialties
- private hospitals, where they would be exposed to treatments not provided or available in the public system
- community services, such as palliative or aged-care, work in hospices, community health and disability services, and community services for Māori and Pacific peoples.
- rural health
- public health medicine.

The emphasis for prevocational doctors-in-training would be on ensuring a mix of placements at different locations and settings so that the doctor-in-training gains the experience required to achieve a general skill mix and advance their personal career ambitions. The criteria for clinical placements are discussed further in section 4.5.

3.1.2 Developing an evidence-based training model for prevocational training

The MTB discussion document on the curriculum framework was the result of a joint MTB and Medical Council working party, and culminated in the paper *The Prevocational Medical Training Competence, Levels and Assessment Principles Discussion Document* (Wilkinson et al 2008). This paper received general support from respondents, who noted the following points:

- the education and training of doctors should be part of a continuum of lifelong learning, with increased continuity between undergraduate, prevocational and vocational training
- training needs that are common across all colleges should be recognised
- the curriculum used in the medical schools, along with prevocational and post-vocational training, needs to be linked to, and overlap with, the previous stage, although there was some confusion about how ‘waypoints’ would operate (a possible model is outlined in Appendix 3)
- there was support both for incorporating the apprenticeship model with workplace and experiential learning, and for enabling progress through the training system, to be linked to the doctor-in-training’s progress rather than having an over-reliance on time-based systems
- as doctors-in-training move through the training continuum, they should be able to concentrate their learning and acquire clinical placements that will give them experience in their chosen specialty, enabling earlier entry to vocational training if desired. Here the new programme of the Royal Australasian College of Physicians (RACP), the Physician Readiness for Expert Practice (PREP), is an example of the way forward.

It was agreed that there should be movement towards an evidence-based training framework across all medical education and training. However, the actual domains, competencies and skills needed, and the format in the *Curriculum Framework* (Medical Training Board 2008b), need more discussion and engagement with the sector before any curriculum framework could be adopted.

It was recognised that the more an educational framework with common outcomes and assessments can be defined, both at the prevocational and vocational level, the easier it will be to allow recognition of prior learning (RPL) at all stages of a doctor’s career. This in turn would introduce more flexibility into the whole system, allowing doctors-in-training who wish to change specialties during their training to move into another specialty without having to start again. It would also enable senior doctors to move to other specialties later in their career, thus improving flexibility in career pathways and increasing retention in later career stages.

Respondents noted that any new system should be built on the positive aspects of the current system and on work already achieved, rather than by introducing a new curriculum at this time.

Rather than the introduction of a new curriculum at this time, the current system needs to be better coordinated, better supported nationally, and better monitored across the sector first.

Before the introduction of a new curriculum, the current system needs to work towards delivering nationally consistent training and common outcomes for all doctors-in-training. The sector needs to be involved in these developments, and the proposals being promoted by the MTB will provide a way for this to happen.

3.1.4 National assessment systems

The MTB agrees that there is a pressing need to design a consistent approach to assessment in the prevocational years, including the need to:

- acknowledge excellence
- recognise the broad value of what has been achieved
- identify those who need additional support.

There are a variety of alternative approaches to assessment, and the MTB recognises that before any changes or specific assessment systems are implemented, there needs to be:

- support for both trainers and trainees in terms of specifically allocated training time
- confidence among senior doctors and doctors-in-training in relation to the rationale behind any specific assessment approach
- transparency in how the personal and system costs of any evaluation processes are balanced against the assurance and monitoring they provide
- a high degree of coherence between the assessment process of the prevocational years and the practices within the medical school and college and vocational branch education and training programmes
- acceptance that assessments must not be too onerous for the trainee or assessor, and should recognise that the vast majority of doctors-in-training function at a highly competent level
- acknowledgement that the points of assessment will not necessarily coincide with any stage of registration, but that there will be a need to evaluate the assessment points that do lead to a change in registration status.

Assessments must be valid, reliable, cost-effective and developmental, and give feedback on learning, foster self-directed learning, and promote application of the skills and competencies learnt.

The system should prepare doctors for the level of self and peer assessment required to participate in continuing professional development (CPD) activities later in their career and to be able to monitor their own performance.

3.1.5 Training and service provision interface

As previously noted, feedback to the MTB indicated that implementation of a national approach to education and training must address some of the shortcomings of the current systems, such as access to meaningful patient contact for doctors-in-training and exposure to a wider range of patients and specialties while also providing adequate supervision.

Due to changes in health service delivery, there is evidence that doctors-in-training are getting less exposure to important areas of practice and skill development. These changes in service delivery have occurred without any consideration of how they have affected the training process meaning there is great variation in the range and quality of clinical experiences. This variation is reported to have lowered general expectations of the clinical competence held by doctors at each level of training.¹³ This perception of insufficient exposure to hands-on clinical work is also apparent for some components of training in medical schools.¹⁴

A number of activities currently carried out by doctors-in-training could be carried out by other health professionals, either separately or working in teams. The system needs to foster local initiatives that look at changes to traditional roles in order to enhance training opportunities for doctors-in-training.

A failing of the current system is that all doctors-in-training, whether or not they are *formally* in training, are required to do clinical placements within the same requirements. In the absence of mechanisms to ensure DHBs provide true training placements, they have traditionally focused on filling 'placement gaps' rather than looking at other ways of performing some services.

In future, the system should be organised so that doctors-in-training are only in clinical placements accredited for training. In addition, any public funding allocated by the CTA would have to be accounted for by the training institution, that is, they would have to demonstrate that the money was allocated to training costs, not used to support operational requirements.

Collectively, the DHBs are beginning to assess whether the required service work could be delivered in other ways, and are doing work on the role of the doctor and the nurse and what service work could be performed by each role. This is not new, and work in this area has already resulted in definitions such as that detailed in the response to the *Curriculum Framework* document by Associate Professor Phillippa Poole on behalf of the Board of Studies, Faculty of Medical and Health Services, University of Auckland. She states:

"Doctors of the future, by training and aptitude, will be the health care workers with:

- *the cognitive and intellectual ability to diagnose patient illnesses, then develop and communicate management plans*
- *the ability to make sound professional judgements and help others to cope where there is clinical uncertainty*
- *the ability to take responsibility for patient management, including when tasks have been transferred to others*
- *a scientific and innovative approach to clinical problems and issues with health care delivery."*

¹³ In a submission to the MTB, the New Zealand Medical Association (NZMA) noted that colleges have stated that doctors entering vocational training are not 'fit for purpose'.

¹⁴ In a submission to the MTB, Dr McHaffie noted that the majority of medical students graduating after a six-year course had fewer than five hours' experience in conducting a full consultation with a real 'new patient while under continuous observation of a tutor who could provide feedback'.

The UK has recently undertaken a wide-ranging consultation on the role of the doctor and the resulting consensus statement is set out in Appendix 4.

Many respondents (including groups such as the New Zealand Medical Association (NZMA) and the New Zealand Nurses Organisation (NZNO)) made the point that, taking into account the differing roles, training, competencies and skills of doctors, nurses and others, continuing research needs to be done to ensure the right people are doing the right work.

If service work is able to be delivered in different ways or by different health professionals (eg, existing roles such as nurses or new roles such as physicians assistants), the role of doctors-in-training can evolve into one more focused on training. Further, increased administrative assistance to SMOs may allow them to be more productive in their role as trainers.

Any new structure for medical education and training should enable training organisations (including DHBs) to provide a number of high-quality clinical placements matched to the number of prevocational doctors-in-training in the system (that is, those that have graduated from medical school and not yet gained general registration) with an allowance for international medical graduates (IMGs) who have passed the New Zealand Registration Examination (NZREX).

If there were extra clinical placements, these could be filled by doctors-in-training who have applied from overseas or have come back from 'time out'. In recent years the number of New Zealand-trained doctors being registered by the Medical Council is always slightly less than the number of graduates from medical schools (Medical Council of New Zealand 2006).

3.1.6 Links to registration

Closer relations between the medical schools, prevocational training institutions, the colleges, and the Medical Council are central to achieving better coordinated medical education and training.

The Medical Council has previously investigated the possibility of a student scope of practice. Several other groups operating under the HPCAA and in jurisdictions in states of Australia have developed a student scope, which means the requirements for appropriate professional attitudes to practice and the protection of registration apply as soon as the student starts working with patients. In addition, a consultation paper distributed in relation to the Australian National Registration and Accreditation scheme, *Consultation Paper on Proposed Registration Arrangements* (Health Workforce Practitioner Regulation Subcommittee 2008), indicated that the preferred option was for student registration for groups that have patient contact, which would enable regulatory boards to deal with students who may have fitness-to-practise issues.¹⁵ With the Medical Council's close relationship with the AMC and the regulatory groups in Australia, this may also be a driver to re-review student registration in this country.

¹⁵ *Fitness to practise* includes:

- being in good physical and mental health
- being able to perform at the required standard
- having evidence of continued competence.

Student registration could help student doctors recognise their professional, legal and ethical responsibilities as soon as they enter medical school. It would also formalise relations between the medical schools and the Medical Council in relation to any possible fitness-to-register issues.¹⁶

In feedback to the MTB discussion documents, it has been noted that the protection of sections 53–62 of the HPCAA relating to quality assurance activities do not apply to students because they are not registered. It was reported that, as a result, it is difficult for medical students to attend some meetings, such as mortality and morbidity meetings, meaning a valuable forum for learning is lost.

Such a change in student registration would require further investigation by the Medical Council because it will require the gazetting of a new scope (or scopes).¹⁷ This could be organised as shown in the table in Appendix 5.

The MTB considers that there would be an advantage to using the registration system and scopes of practice so that they reflect the continuum from student doctor to specialist, and will work with the Medical Council to progress this issue.

3.2 Specific issues related to vocational training

This report's primary focus is on the prevocational years, but, as has been noted, a goal of the MTB is to ensure medical training is coordinated at all levels.

Alignment in training that is common across all colleges should be progressed.

The MTB wishes to ensure that in any future system the number of publicly funded vocational training posts in each field is linked to the number of specialists New Zealand needs.

3.2.1 Coordination of common modules and resources across vocational training

The development of common core modules in vocational training would be beneficial. This could initially occur in common areas such as communication and professionalism, but in the medium term it could also occur in areas where the matters to be taught have common strands. Alignment with areas taught in the prevocational years would also smooth the transition from one form of training to the other.

¹⁶ *Fitness to register* includes:

- having the appropriate standard of qualification
- being able to communicate effectively in the jurisdiction
- being of good character and a 'fit and proper' person
- having an absence of relevant convictions for indictable offences, statutory offences relating to the professional's practice, and findings of guilt in either civil or disciplinary proceedings in any jurisdiction
- having an absence of relevant current criminal or disciplinary investigations in other jurisdictions.

¹⁷ A scope of practice refers to the health services that form part of a health professional's practice.

The sharing of training resources and teach-the-teacher programmes would also be beneficial. Currently the colleges develop their own training resources, with little cross-sector coordination. A simple first step would be to stocktake all college and vocational branch resources and to publish this information so that colleges can see what others have available and either make an agreement to access each others' material and/or allow each others' doctors-in-training to access what they need, regardless of the college and vocational branch of origin. This would be especially useful in relation to resources such as those on the medico-legal aspect of practising in New Zealand and in relation to cultural competency.

3.2.2 Current funding of vocational training posts

Post-entry Clinical Training (PECT) funding needs to link explicitly with clinical placements and be based on the number and mix of specialists New Zealand needs.

The number of training posts currently relates (at least in part) to the allocation of PECT funding by the CTA. The CTA funds some – but not all – vocational trainees in most vocational branches. The CTA position is that posts are fully funded, but both DHBs and some colleges contend that posts are not fully funded because DHBs can develop additional training posts and spread the CTA funding over the posts created.

Prioritisation of the number of training places to be funded by the CTA in each specialty area depends on direction from government, government policy, workforce need, Māori development initiatives and price acceptability. But as DHBs and colleges can develop additional posts, the number of vocational training posts depends not only on CTA funding, but also on college and vocational branch advocacy and on the enthusiasm of SMOs.

Currently there are anomalies and different funding allocations across some vocational areas, such as general practice, AMP, family planning and public health medicine, which any new system should address.

General practice

In 2009 the RNZCGP is training 125 first-year general practice registrars (GPEP1) and approximately 400 in GPEP2,¹⁸ while the CTA has funding available for 129 first-year registrars. For the past six years the CTA has paid a contribution to training costs of \$2,350 to 50 second-year senior registrars and 50 third-year senior registrars. The remaining 350 doctors had no CTA contribution.

First-year general practice registrars receive a 'bursary', while senior general practice registrars (in the second or third year of general practice training) seek employment with a general practice or work as self-employed doctors.

Teachers of PGY2 doctors in general practice runs and teachers of registrars get a modest allowance. Teachers of undergraduates are paid varying amounts, which are not standard across year groups or across the country.

Other groups

Currently AMP does not gain any CTA funding for training. The training costs are paid by the doctor-in-training or by the clinic that employs the trainee. Family planning does gain some

¹⁸ GPEP2 is stage 2 of the programme, undertaken by second and third-year senior registrars.

CTA funding for the delivery of the Diploma in Sexual and Reproductive Health, which is a postgraduate diploma delivered by a charitable educational trust. Funding covers course materials and tutor and supervisor costs, and makes some contribution to students' salary. Additional costs are met by the student personally.

In public health medicine the CTA funds the New Zealand Population Health Trust to deliver the training programme. Basic trainees receive a bursary similar to the RNZCGP, while the training sites of advanced trainees are able to invoice the Trust for a defined training allowance per trainee.

Greater transparency and consistency in PECT funding should be a goal of any future education infrastructure.

3.2.3 Accreditation of training posts

In vocational training the specialist colleges decide which departments or individual posts can be recognised for training and who can be college or vocational branch supervisors of doctors-in-training. This differs from prevocational training, where currently the Medical Council accredits most of the clinical placements. (The exception is in general practice, where the colleges allocate doctors-in-training to college-accredited teaching practices.)

The colleges are accredited by the Medical Council in conjunction with the AMC, and this process takes into account principles and systems relating to training. As a result, the MTB believes there is no need to change the current accreditation system, as the Medical Council is involved in the process for both prevocational and vocational training; in the latter case it accredits the system and in the former it accredits the actual placements.

3.2.4 Vocational training in the future

As has been noted in previous MTB reports, work needs to continue to match vocational training levels and funding to future health service needs. Such reviews of the number of places needed should take into account:

- the age distribution, and the increasing median age, of doctors in some fields¹⁹
- increasing pressure for a work–life balance with fewer work hours, driven by a range of factors including the feminisation of medicine, as women work fewer hours,²⁰ and differing life priorities of the coming generation of doctors
- support for smaller specialties (eg, palliative care and neonatal pathology)
- allowing clinical placements in alternate settings including private hospitals, general practice, and other community settings.

The CTA, in conjunction with District Health Boards of New Zealand (DHBNZ) and the Health Workforce Information Programme (HWIP),²¹ has started research and modelling on the number of doctors to be trained in each specialty. This work must continue.

Any future system for vocational training should:

- be linked to the number of specialists New Zealand needs in the future

¹⁹ See Medical Training Board 2008a, Figure 16.

²⁰ See Medical Training Board 2008a, Figure 75.

²¹ The Health Workforce Information Programme is a strategic framework that will deliver a health workforce information system to enable a central point for the collection of health workforce data throughout the health sector, along with comprehensive analysis, modelling and forecasting of that workforce data, which will produce key information for health workforce management and planning.

- coordinate the common elements of training and development of resources across the colleges and vocational branches where possible
- move towards enabling doctors-in-training to enter 'starter' vocational training programmes soon after gaining general registration
- move towards a similar funding base for all Medical Council-recognised vocational branches so that there is equity for both doctors-in-training and clinical supervisors across programmes.

Section 4: How to Achieve Change

It is not the strongest species that survive, nor the most intelligent, but the ones most responsive to change. (Charles Darwin)

4.1 Laying the foundations

Given the intensity of pressures on the sector and the variety of training providers, without some national oversight the current system will have difficulty responding when the number of doctors-in-training doubles. A new infrastructure is required.

This situation is not dissimilar to that in Australia, where a recent paper on health education and training (National Health Workforce Taskforce 2009) noted that a number of features of existing arrangements are working reasonably effectively, and that the current arrangements are characterised by a 'range of collaborative relationships. However, existing relationships focus on specific elements of clinical education arrangements rather than overarching policy, system development and best practice'.

The Australian paper also notes that New Zealand, with funding already centralised by the CTA, has some aspects of 'national organisation'. The paper goes on to argue that national organisation provides an opportunity to establish 'clear governance arrangements' and to address 'current issues with clinical placements to ensure clinical training occurs in the most integrated and educationally effective way with appropriate support for planning and coordination at regional and national level'.

Both the long-established CTA and the more recently established MTB can provide the basis of a new body founded on well-informed capacity to bring authoritative leadership and effective and well-systemised processes to the sector.

Any new structure must have clearly defined roles and accountabilities, and needs to have clearly spelt-out relationships with other groups in the sector.

4.2 The role of the Medical Training Board

The MTB was established to provide leadership in the education and training of the medical workforce and to report to the Minister of Health and the Minister for Tertiary Education. Its main role is to provide strategic oversight of the education and training of medical practitioners and to work towards a system that produces practitioners who are 'fit for practise' and who meet the needs of the health sector. The MTB was also charged to work with others in the sector in order to ensure a 'coordinated approach to the development of a competent and relevant medical workforce'.²²

The quality of the medical training system and the arrangements for the employment of doctors-in-training have an impact on the capacity of New Zealand to retain doctors that are explicitly trained to advance medical services in New Zealand. In ensuring that the New Zealand health service is well equipped to compete with external markets, efforts are diluted by the form, extent and significance of competitive activity within the New Zealand health service across the 21 DHBs.

²² MTB terms of reference.

The health service at present has not faced up to the need for more effective ways to recognise the differences in the variety of pressures faced by the smaller regional DHBs compared to those faced by the larger tertiary DHBs. Because of the needs of the system as a whole, at present these regional issues are rarely examined, but choices faced by smaller DHBs in maintaining services are often at the expense of the overall integrity of the system. The dependence on overseas recruitment – not only for senior doctors but also to fill the placements of doctors-in-training – is a significant failure of New Zealand’s workforce planning that has placed huge pressures on the medical training system.

An effective whole-of-system governance process can increase our capacity to deliver medical training New Zealand-wide over the next decade, when medical resources will be under increasing pressure.

Currently the MTB’s functions are primarily facilitative, working with others to review and develop the next steps to progress and give effective ‘oversight and coordination of the continuum of medical education and training in New Zealand’.²³

A new grouping with different authority and support systems is needed. The MTB proposes a new body, Medical Education and Training New Zealand to fulfil this role.

4.3 Medical Education and Training New Zealand (METNZ)

The MTB proposes a new body be created – Medical Education and Training New Zealand (METNZ). To enable this new body to work across the sector it needs to have credibility and the support of all groups.

The work of the MTB has been well accepted by the sector to date, and feedback on the discussion documents indicates that the MTB is seen as being able to lead changes in the areas of medical education and training, making it an ideal body to take on this role. However, the MTB in its current form and with its current terms of reference is not in a position to engineer the changes needed throughout the sector. The MTB has no authority to ensure that common practices, once agreed, are adopted, and it has no authority over resource allocation or to challenge operational priorities. Finally, the MTB has no process for managing operational relationships and no authority to require access to information of any form. It has, however, established a constructive relationship with the CTA, which provides a good basis from which to start.

As a result, the MTB is recommending that it evolve into a new board, with extended terms of reference to enable it to have a wider focus and responsibilities. This new board would be the governance body for METNZ, and the current MTB would be disestablished.

²³ Medical Training Board terms of reference.

This board would concentrate on strategic focus, generative thinking and fiduciary care²⁴ to ensure that policy development in the area of education and training provides the number and type of doctors to meet New Zealand's health service needs. In time, based on experience, consideration could be given to a wider health authority for professional education, training and development throughout the sector.

The role of METNZ at the governance level would be to:

- give strategic direction to the delivery of medical education and training in New Zealand
- provide leadership in medical education and training
- ensure policy and research take place to inform strategic medical education and training decisions in relation to workforce needs
- provide evidence-based advice on medical education and training to the Minister of Health on the number of doctors that need to be trained, in terms of the number of entrants for medical schools and the number of specialists required, and funding allocations for each area of specialty training
- raise the profile of medical education as a discipline and a legitimate field of study, and encourage research in the area of education delivery and assessment
- ensure the board is informed on debates within other bodies, such as those involved in training and education in other health professions
- continue the debate about roles in the health sector with other bodies that are involved in training in nursing, midwifery and allied health services, and provide an interface with others in the medical and education sector at the governance level
- be responsible for the operational aspects of the national coordinating body
- oversee the employment of a chief executive.

METNZ board members would have to relate to and be informed by the current groups in the medical sector, such as the Medical Council, colleges, medical schools or other national medical groups, but should not be representative of these groups and not be constrained by traditional health professional boundaries or current service delivery models.

Members of the METNZ board would be appointed by the Minister of Health, selected for their governance ability and knowledge, their creativity and ability to achieve change in a complex environment, and their ability to focus on finding solutions. Most members of the board should also have expertise in medical education and training, assessment systems and health service delivery.

The METNZ Board would be accountable to the Minister of Health.

²⁴ Richard Chait defines the roles of a governance board as follows: *strategic role* – to review the vision, mission and strategic plan; *generative role* – to act as a source of leadership for the organisation to identify and solve problems and build on opportunities through strategic/forward thinking; *fiduciary role* – to monitor organisational and financial performance, monitor risks and protect the organisation's assets.

The Ministry of Health has long needed to play a more effective role in relation to the capacity of the health service to deliver services of high integrity, and to oversee investment to a level that can be sustained, such that New Zealand can compete internationally for health professionals and retain New Zealand-trained graduates. The Ministry of Health alone has the capacity to ensure that the balance of workforce needs and supply reflects the fiscal and other constraints of government, New Zealand's international position and obligations, and the wider industrial setting in New Zealand.

METNZ would make a unique contribution consistent with this by providing the capacity to balance the need for coherent long-term strategic responses to medical workforce supply issues and the more pragmatic tactics used by DHBs to meet their own comparatively unique, shorter-term needs as they respond to the unpredictable elements in the local demand and supply of medical services. At present no such capacity exists.

METNZ will have the capacity to challenge the fit of the strategic responses, and to manage the tensions brought about by the tactical responses of DHBs. A common resource base is essential, and it is also essential that the commitment to this should no longer vary according to the strategic responses of the Ministry of Health. METNZ would bring about increased confidence in the sustainability of information sources, and would clearly have a significant part to play in the balance of responsibility for this.

To gain the confidence of the sector and have the ability to make independent decisions and work across the large number of groups involved in medical education and training, METNZ could not function on varying support from the Ministry of Health for some of its functions. METNZ will need to have its own secretarial and servicing support once it has specific ongoing responsibilities that are part of the decision-making process of the health sector.

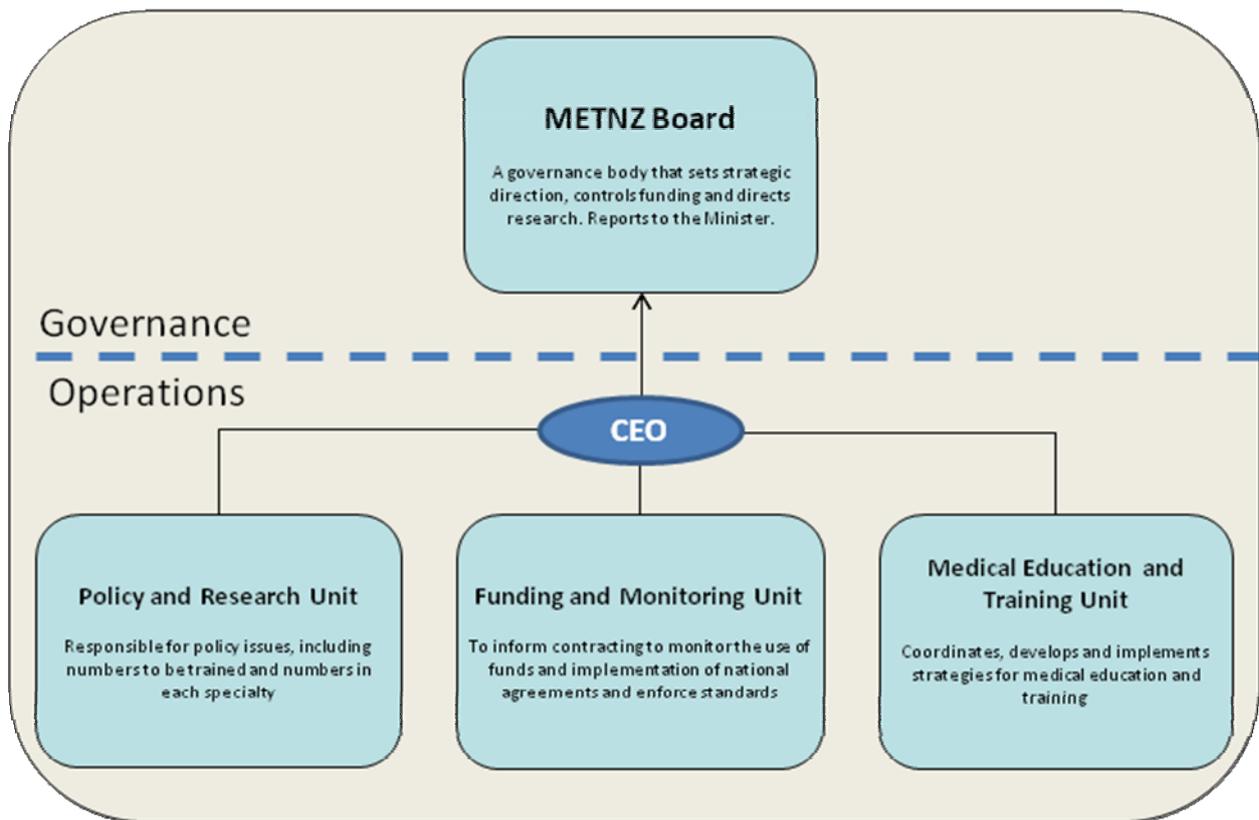
The links between METNZ and the Ministry of Health will be vital to its success. The Director-General of Health or his/her delegate must be a member of the board of METNZ. METNZ would also have ongoing links, and be required to consult with, the Ministry of Education and the Tertiary Education Commission.

METNZ would have three operational 'arms' or units and administrative capacity. These units would be responsible for:

- planning and research
- funding and monitoring
- coordination of medical education and training.

If METNZ did eventually take on the responsibility for coordinating all health education and training, another two to three additional units could be added at this level (ie, nursing, midwifery and/or allied health). METNZ would be headed by a CEO, and would have secretariat staff that would service the board and deliver common administrative services across the units of METNZ.

Figure 1: Structure of METNZ



4.3.1 Policy and Research Unit

METNZ needs strong *policy and research capacity* so that it can continue the analysis already started in the discussion document *The Future of the Medical Workforce*. This would be most effective if METNZ utilised the expertise currently within the CTA. This has been the basis of the work done by the MTB on workforce planning, and has been most successful.

In the short term this Policy and Research Unit would continue work on assessing the number of vocational trainees needed for the development of a specialist workforce that is aligned with future priorities in service provision. In the medium term, modelling and workforce development expertise will be needed to ensure the number of doctors-in-training in the various specialty areas or branches of medicine continues to meet the needs of the New Zealand health service.

The unit would include research and planning capacity to enable METNZ to advise the Minister on:

- places needed for training at medical school and the number of clinical placements needed for medical students
- the number of doctors-in-training and the number of clinical placements needed so that all medical school graduates can access the prevocational training they need to enable them to be registered by the Medical Council
- sufficient vocational training posts to allow doctors-in-training to progress to vocational registration in vocational branches or specialist areas that meet future health service needs.
- the development of part-time, flexible and/or alternative roles
- initiatives to improve Māori and Pacific recruitment into medical school.

The Policy and Research Unit would work collaboratively with the Ministry of Health and DHBs and would be led by a manager.

4.3.2 Funding and Monitoring Unit

This unit would be formed from the existing CTA and is intended to more strongly support the *allocation of funding for prevocational and vocational medical education and training* (currently managed by the CTA), along with any additional funding for education and training in medicine for prevocational and vocational training. The METNZ Board will maintain a strategic focus over the next decade in this important and influential work as trainee numbers double.

A substantial increase and/or re-allocation of funding will be needed so that the funding flows accurately and reflects training requirements, particularly for prevocational training, as set out in sections 2.3 and 6.2. This unit would be expected to facilitate increased coordination between the variety of funding sources for medical education and training.

If the strategies discussed in this report are to work, it is essential that the distribution of, and accountability for, funding are a function of the activities of METNZ.

METNZ would also need *a strong monitoring function* incorporating part of the CTA to monitor spending on medical prevocational and vocational training and education. This monitoring needs to be enhanced to ensure the government gets 'value for money', and so that all parts of the medical education and training sector are accountable for the expenditure of government funding. The unit would be led by a manager.

4.3.3 Medical Education and Training Unit

In light of the considerable government investment in the area of medical training and education, a specific national education and training unit should be formed to oversee, coordinate and standardise outcomes in medical education and training across the whole continuum and the lifetime of the doctor. This unit would be called the Medical Education and Training Unit (METU).

METU's primary role would be to promote national coordination and cohesion in medical education and training and ensure that appropriate regular consultation with all groups involved in medical education and training occurs. In relation to the coordination of prevocational doctors-in-training, METU would be responsible for:

- the promotion of common structures and common outcomes for prevocational education and training, in conjunction with the current groups involved in training, including the Medical Council, the medical schools and colleges, and other vocational branches
- the coordination of a mapping process (similar to that being done by CPMEC²⁵) identifying suitable training clinical placements that can be used by doctors-in-training to gain the competencies and skills necessary for general registration, which in time could lead to the development of a common curriculum

²⁵ The Confederation of Postgraduate Medical Education Councils (CPMEC) is an association of postgraduate medical councils of each state or territory in Australia, which works with the Medical Council.

- a stocktake of all resources currently being used in the sector to train PGY1 and PGY2 to promote best practice and innovative ideas, which should also link with the similar CPMEC project²⁶ and minimise the duplication of resources that is currently endemic in the sector
- developing, in conjunction with the sector, an agreed assessment system
- providing information for trainees, similar to *The Rough Guide to Foundation Training* (Modernising Medical Careers 2005)
- in conjunction with the Medical Council, colleges and other vocational branches, coordinating the standards and training required for the trainers of doctors-in-training (ie, educational and clinical supervisors)
- stimulating the development of vocational guidance and mentoring for doctors-in-training in their career choices, along with avenues for remedial action if they are experiencing difficulty progressing through training
- developing quality indicators by which to assess the provision of training in the prevocational years
- in conjunction with the Medical Council, colleges, DHBs and other potential training institutions such as RNZCGP, developing the requirements for clinical placements
- developing a coordinated information system for trainers to network and share clinical supervisor training resources, so that doctors-in-training have access to information and are able in the future to store electronic records of learning or portfolios
- working with colleges to develop 'readiness for expert practice' programmes, such as those planned by the RACP, or 'specialty teaser' courses, as are being trialled in the UK, so that those who have already made a specialty career choice can make the most of their prevocational training, and those who have yet to decide are able to experience work in a specialty area.

The METU would facilitate the coordination of resources that are currently being duplicated as each DHB, college and other vocational branches develop their own resources in isolation.

METU would also:

- encourage the trend towards evidence-based training in the colleges and vocational branches
- work with colleges and vocational branches to develop a consistent approach and, where possible, common modules of learning that could be delivered across all colleges and vocational branches
- prescribe (with input from the Policy and Research Unit) the number of vocational training posts required to ensure there are sufficient posts to meet projections of the various specialists needed in the future for effective patient care
- monitor the quality of training in these posts across all specialties in conjunction with the Medical Council and the AMC.

²⁶ A National Stock-take and Online Catalogue of Courseware Mapping to Australian Curriculum Framework for Junior Doctors is being undertaken by the Centre for Health Innovation and Solutions at the University of Queensland. The aim of the project is to develop a consistent national standard for cataloguing educational assets, to undertake a stocktake of current educational resources, and to develop a searchable, sustainable online catalogue of these resources.

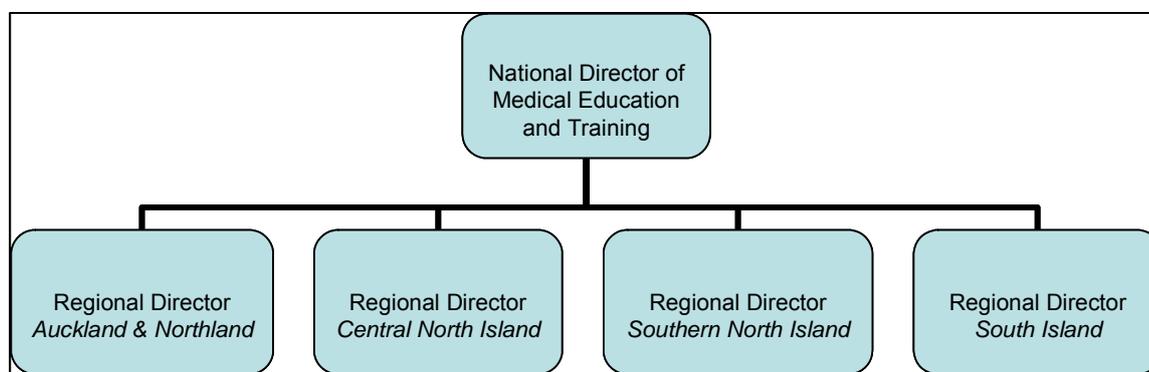
In relation to the medical education and training sector as a whole, METU will:

- strengthen links with undergraduate and postgraduate trainers and ensure, through facilitation, a smooth transition throughout the learning continuum, from student education to vocational training
- support research and cross-fertilisation in areas of education, training and assessment
- work with others in the sector to develop ways to assess prior learning and promote the recognition of prior learning across the sector.

METU would be headed by a national director of medical education and training (the national director), who would be accountable to the CEO and Board of METNZ. METU would also employ regional directors in each of four regions. The roles are set out in Appendix 6.

The structure of METU would be as shown in Figure 2.

Figure 2: Structure of METU



4.3.4 Regional education and training units (RETUs)

To be able to coordinate medical education and training nationwide and work effectively with existing groups across the sector, METU would need a regional presence.

Four regional education and training units (RETUs) would be formed.

The four regional education and training units (RETUs) should be aligned with existing clinical networks of care based in the Auckland and Northland areas, the central North Island and Waikato, the MidCentral and Wellington areas, and the South Island. These areas have a similar population base of 800,000 to 1,200,000. As population growth is likely to continue in the northern areas of New Zealand, the Northern region could, if necessary, become two units in future.

The RNZCGP already coordinates national vocational training in general practice via three regions, being Auckland and the North, the rest of the North Island, and the South Island. Within these regions medical education is delivered by the RNZCGP from 11 centres, which relate to the demand for registrar placements. It is feasible these could be mapped onto the four regions of METNZ, which would also link with the development of regional 'outreach programmes' of the medical schools and rural and general practice placements in the medical schools.

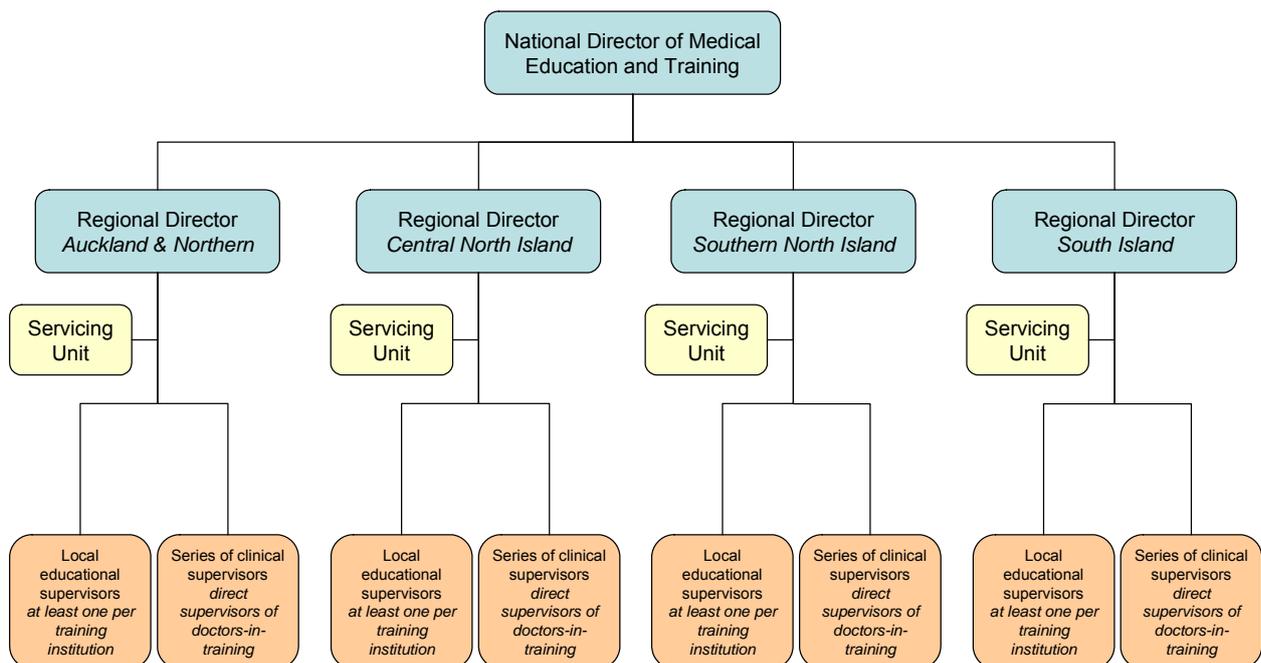
RETUs would:

- ensure national initiatives are implemented regionally and locally, and coordinate the delivery of training and assessment in the regional and local areas
- relate to doctors-in-training regionally and help educational supervisors to monitor the performance of doctors-in-training
- relate to, and have a performance contract with, local educational supervisors (and any educational directors appointed), although these people (as now) would be employed by the training institution where they work
- deliver training to those involved in training in the region – ie, teaching the trainers
- act as a coordinator for resource development and integration across the region.

The regional units would be headed by regional education and training directors (regional directors), who would be supported by small servicing units, which could be created utilising the expertise currently residing in units such as the Clinical Education Training Unit at Auckland DHB and the Medical Education Training Unit in the Canterbury DHB.

The regional education and training directors would be employed by, and accountable to, the national director of education and training. Their role is set out in Appendix 7. They would have a functional relationship with the educational supervisors and clinical supervisors, who would continue to be employed by the DHBs and other training institutions in the sector. These relationships are shown in Figure 3 below.

Figure 3: Links between staff of METU and RETUs and doctors involved as trainers



4.3.5 Staffing, responsibilities, accountabilities and incentives for medical education and training at the institution level

Educational supervisors (and education directors if appointed)

To ensure delivery and coordination at a local level, each training institution (DHB, private hospital, general practice or community service) would be required to have at least one *educational supervisor*. This would be a similar role to the current intern supervisor role for PGY1. The educational supervisors would be responsible for ensuring doctors-in-training had induction and ongoing formal education and training opportunities, and would have the *day-to-day responsibility of ensuring the agreed common outcomes required are delivered*, as set out in Appendix 8. Educational supervisors would also have a coordinating role across training in their institution, and may also coordinate training and clinical placements in other services and other settings, such as in private hospitals, general practice and other community services in their area.

If the training institution is large enough, they may have a lead or senior educational supervisor, an *education director*, who would be responsible for coordination across the institution and may also coordinate clinical placements across different services and different settings.

Although educational supervisors would continue to be employed by DHBs and other training institutions, in terms of accountability for medical education and training they (and their directors) would have a contract with RETU that includes key performance indicators (KPIs) for the delivery of defined services relating to medical education and training to ensure accountability to the national system. This would be similar to the contract intern supervisors now have with the Medical Council²⁷ for PGY1 doctors-in-training. They would receive payment for this work from RETU, as they do now from the Medical Council (currently this loading is \$740 per annum per doctor-in-training supervised).

As happens now with intern supervisors, training institutions (except in general practice) would be expected to allocate defined tenths of their time for an educational supervisor to relate to a certain number of prevocational doctors-in-training so that a personal relationship is built up between them, and to ensure this relationship continues throughout the period the doctor-in-training is working in that training institution even if he/she changes clinical placements.

Educational supervisors would be entitled to administrative support to assist them in their job of coordinating training and assessment. Currently many DHBs have RMO Units that assist in this way, as well as performing other tasks. Educational supervisors should also forge formal links with medical schools in the region to give academic mana to their position and to help ensure seamless transition for students from medical school to prevocational training.

Clinical supervisors

Each training institution would continue to have a *clinical supervisor* for each doctor-in-training. Clinical supervision is defined as a structured relationship between similarly trained professionals that supports the apprentice model and is very similar to the role that SMOs play now to their Registrars and House Officers. The role would be enhanced however, with greater support for the trainer. The proposed role is set out in Appendix 9.

²⁷ Currently intern supervisors are nominated by the DHB's chief executive officer. The Medical Council approves the person and has a contract with them for a term of appointment of *five years*, with opportunity for renewal. Intern supervisors should not have a management role within the DHB.

The relationship will need to be closer than sometimes happens at present in prevocational training placements, where some respondents report clinical supervisors who do not know the names of the doctors-in-training in their clinical placement.

The clinical supervisors would be required to meet regularly with the educational supervisor in their area to encourage sharing of expertise and knowledge, and to increase consistency across specialty areas.

In prevocational training there would be an agreement between the training institution and RETU such that the training institution guaranteed that clinical supervisors would be accountable for meeting the minimum requirements of supervising a doctor-in-training in a clinical placement. This would include regular contact and formal feedback, at least at the beginning, middle and end of a clinical placement, and reporting to the educational supervisor as required so that multi-source feedback can be given to the doctors-in-training periodically. This needs to be enforceable, as there is agreement in the sector that the amount of face-to-face supervision time for many doctors-in-training with their supervisors needs to increase in order to retain effective apprentice learning.

In vocational training the clinical supervisor would continue to be appointed and supported by the relevant college or vocational branch.

Incentives to be involved in training

Approved clinical supervisors would be allocated an 'allowance' or incentive to be involved in education and training, and would need protected time to undertake and prepare for their supervision responsibilities.

Supervision in general practice

In general practice, prevocational training is organised by, and funded through, the RNZCGP. This is different to all other colleges and vocational branches. Currently the RNZCGP only has one three-month rural general practice rotation for prevocational doctors-in-training. These rural attachments provide hands-on experience, with teaching from an accredited general practitioner teacher in a supportive general practice environment. The RNZCGP also has national facilitation of training.

The general practitioner teacher would be similar to the clinical supervisor described above, and the RNZCGP programme facilitator would be equivalent to an educational supervisor.

In vocational training, registrars nominate the regions in which they wish to train, with each region having a number of teaching practices available, and they are assisted by approved teachers – again similar to the clinical supervisor role in DHBs.

4.4 Training institutions and clinical placements

Training institutions involved with doctors-in-training gain a significant contribution from their involvement in the health service, as doctors-in-training encourage innovation, challenge, enquiry, the applications of technology, research and a high-quality learning culture.

Currently it is difficult for the smaller service delivery organisations to be involved in the training of doctors, as they may not have the necessary organisation and / or physical resources to train, including rooms to enable doctors-in-training to undertake clinical activities on the premises, and there is little recompense for service slowdown and back-filling when the doctor-in-training is in formal learning, or to reward SMOs for their increased supervision load.

As with DHBs, any private hospital, general practice, or community group could offer useful experience and training, and should be encouraged to do so. Institutions should work together to develop clinical placements that give doctors-in-training wider exposure to clinical practice; for example, through developing a clinical placement that covers work in a DHB surgical department and a private surgical hospital, or a placement that includes working in a general practice one day a week.

In the proposed system, money allocated to training by the CTA *would be allocated directly to each doctor-in-training*, so that the training institution would have to apply this money directly to training costs. In return, the training institution would have to allocate the doctor-in-training to a quality clinical placement and a formal education programme, and supply the services of an educational supervisor and clinical supervisor to assist the doctor-in-training.

The financial incentive given to training institutions would be directly linked to employment of the doctor-in-training, and would be auditable to demonstrate it is allocated directly to costs associated with training.

To be *accredited*, the training institution must be able to:

- meet the terms and conditions set by METU, including providing a safe working environment and guidelines on safe hours of work for the doctor-in-training and their supervisors
- provide accredited clinical placements and have a robust system for assessment within the national guidelines
- provide adequate space for trainee support and access to educational resources, such as being able to provide access to skill labs and online systems for alternative learning
- have mapped their clinical placement objectives against the agreed competencies
- have systems for ensuring staff are able to provide and support the training requirements of the accredited clinical placements
- assist in remediation if a doctor-in-training is not progressing as expected
- preferably offer training throughout the continuum of a doctor-in-training, so that a more experienced doctor-in-training can assist, train and assess those with less experience than themselves
- provide an adequate learning environment that includes access (but not necessarily on-site provision) to learning resources / a library, online learning systems, skills lab, etc
- demonstrate that it could produce the outcomes required in the agreed set of competencies across the range of clinical placements on offer
- give choice and options to ensure the clinical placements cater to the differing learning styles of doctors-in-training and provide a balance of service provision and learning and reflection
- enable doctors-in-training to achieve the competencies in a range of settings, where the actual competencies learnt are probably more important than the discipline they are learnt in
- be flexible to allow for part-time work and study, time out or time off, without penalty
- have clinical placements of varying lengths to give opportunity for in-depth links in a health care team
- provide career advice and mentoring.

Any new training institution would be accredited by the Medical Council as an appropriate place for training a doctor-in-training and must meet the above criteria.

To encourage DHBs to be training institutions, the amount of training achieved in the DHB would be included in performance measures, as all institutions in the sector need to continue to support medical education and training.

The METU would work with the Medical Council to use these criteria to develop a simple set of national standards. This would include obligations to oversee safe hours and overall workloads, which may need a stronger legal basis or the development of a set of national standards.

4.5 Employment of doctors-in-training

The proposals for METNZ recognise a need for significantly strengthening nationwide coordination of the training of doctors separate from the nature of their employment arrangements.

Fundamentally, in order to be successful, an integrated, coordinated system needs to ensure three objectives:

1. protection and recognition of trainees and trainers
2. ability to train with alternative providers
3. that training funding is spent on training.

There are a number of mechanisms that could be applied in whole or in part to achieve these three objectives including:

- increasing accreditation requirements and enforcement
- increasing contracting and audit requirements
- increasing training subsidies
- a change to the employment model.

Improvements to the system for medical training will be constrained by the extent to which the system can protect trainees from inappropriate non-educational service provision, and whether doctors-in-training can access enhanced clinical educational experiences.

The MTB recognises that proposals relating to an employing body for doctors-in-training are under consideration by the RMO Commission and that justification for such an employing body would primarily be based on considerations other than training. However, given the impact on the medical training system it justifies consideration in this report. It is important to emphasise that changing the employment arrangement for doctors in training is neither a substitute nor a prerequisite for the proposals contained in this paper.

Currently, prevocational doctors-in-training are employed directly by a DHB; and when they move to another DHB, their employer changes. This requires DHB hospitals to set up and monitor the employment of doctors-in-training and is a barrier to other potential training institutions, such as general practices or private hospitals, becoming involved in education and training.

There could be benefits to the system as a whole, and for the doctors-in-training, if there was a *single employer*. These benefits could include:

- clearly delineating doctors-in-training and highlighting their training function
- a reduction in the duplication of efforts for those applying from overseas, and the ability to allow for national placements (selling New Zealand experience, not just experience of a single centre)

- certainty around the supply of doctors-in-training would force institutions to critically appraise the way in which services are delivered, potentially stimulating the development of complementary roles
- creating competition among training institutions to provide for excellence in training experience
- easier administrative processes for doctors-in-training, both on application and at change in clinical placement
- the ability to track national work and training requirements for formative learning across training institutions
- continuity of formative training among training institutions.

A single national employer would not be without risks however, some of which could include:

- the potential for poor governance and bureaucratic inefficiencies
- the potential for poor implementation
- a separation of the doctor-in-training from their employer.

It is important to emphasise that changing the employment arrangement for doctors-in-training is neither a substitute nor a pre-requisite for the proposals contained in this paper.

4.6 Coordination via an information system

To coordinate the system of medical education and training, good information is required. METNZ needs to ensure an information system is developed that can:

- increase the capacity for multiple use of high-quality training resources and, where relevant, give leadership and support to initiatives for the development of training resources and online courses
- coordinate the placements of doctors-in-training in training positions in the community, in primary health care and in rural environments.
- obtain and manage information relating to the training plans of, and training received by, individual doctors-in-training, from the point of graduation onwards
- inform clear workforce volumes and training numbers
- transfer training information on doctors-in-training between providers where appropriate²⁸
- develop and facilitate networks and cross-provider clinical placements
- track national doctors-in-training portfolios if developed.

This system could also assist doctors-in-training and training institutions (including medical schools) by making widely available simple processes using contemporary technology to track clinical placements within a region. This sort of system will be needed in the future to coordinate prevocational clinical placements and general practice teaching practices to students and doctors-in-training. The increase in the number of doctors-in-training will necessitate access to effective processes of this type.

Any such allocation processes would be introduced using similar principles to the existing Advanced Choice in Employment (ACE) scheme that operates for PGY1, in particular that applicant choice takes priority.

²⁸ Any system would need to be set up to be consistent with existing employment and privacy legislation.

Such a system must not be used to 'place' doctors-in-training against their will in order to meet service needs, as this would be counterproductive to the educational principles being promoted in this report.

If doctors-in-training had 'real time' access to the information system (similar to an automated booking system), they would be able to use the information to review the clinical placements available and assess their choices. The system could also map vocational posts within various specialties so that doctors-in-training could assess which specialties and which posts could meet their requirements.

The system could also assist the placement of doctors-in-training into general practices. If medical schools had access to the system they would be able to use the information to assist in the placements of students.

As well as coordinating and assisting with the allocation of placements, if such a system were used by all concerned from student years to vocational training, it could bring the sector closer together and help the doctors-in-training to see the medical education and training systems as coordinated and linked.

The development of a national information system would be an early priority of METNZ.

4.7 Incentives to be involved in training

Doctors-in-training need incentives to be involved and remain in the system. These should involve a balance of non-monetary and monetary incentives. The non-monetary incentives are fundamental to the continued long-term integrity of the system of training, and the consequent value placed by the doctor-in-training on continuing to work in New Zealand after graduation.

The part financial incentives play will vary according to the effectiveness of strategies to ensure the New Zealand health service can compete effectively for resources in international medical labour markets. Judgements about their nature and scale will vary more over time than for non-monetary incentives.

4.7.1 Non-monetary incentives

Quality training

Clinical placements should be of high quality, with a focus on exposing doctors-in-training to a wide variety of clinical practice and settings. To achieve this, doctors-in-training should be allocated quality time with senior doctors and given direct feedback at least three times during a clinical placement. The doctors-in-training should have sufficient exposure and types of training to enable them to meet the required competencies and to accommodate different ways of learning and learn different ways of doing things.

Flexibility

It is important that the way the training is structured enables flexibility and meets the variety of needs of doctors-in-training (some want to complete their training as soon as possible, others

may want time out) and different learning styles (some learn by watching, others by doing, and some learning needs to be in formal settings while some is opportunistic).

The system of training needs to have as its main driver the completion of a vocational training programme in the minimum reasonable time, but there are an increasing number of doctors who find that extending the period of training is more appropriate for their circumstances. Currently, some doctors defer entry into vocational training because they can gain rewarding salaries for working in shortage areas. This will not necessarily be a long-term phenomenon, but its significance at this point in time means that it may obscure other fundamental shifts that many doctors now want to see in medical training.

As the Training the Medical Workforce 2006 and Beyond (Ministry of Health 2006) report noted:

“Trainees want access to quality teaching and mentorship with flexibility. This flexibility takes a number of forms ... modular portable programmes, recognition of prior learning and work–life balance. Training should be an integral part of the job not just something to fit in if there is time.”

The ideal system would allow doctors-in-training time out from active training, give flexibility and accommodate personal life situations. This would also give the doctors-in-training some flexibility to take part in other electives, such as research or working overseas, and the option to do further study (eg, in medical management or research).

The doctor-in-training could move from provisional to general registration at his or her own rate, within minimum requirements and as long as they gain the skills required. Doctors-in-training could have a record of learning or portfolio and be encouraged to take control of their own learning. The portfolio could have tools to assist them to identify where they lack expertise, be a record of what they have achieved, and help them identify gaps in their learning.

Understanding the system

The MMC programme has shown that doctors-in-training must understand the new system, and they must be assured they will be entitled to clinical placements to enable them to get registration, and that their preferences for location and type of work will be taken into account. The MTB endorses these assurances.

To ensure doctors-in-training understand the new system, one of the early tasks of METU would be to prepare information for doctors-in-training on how the system would be implemented. Information would also need to be provided for those doctors-in-training needing a break from training, information about medical specialties and shortage areas, etc.

4.7.2 Monetary incentives

The need for monetary incentives will depend on the imbalances in the supply and demand for doctors. Given that the demand for doctors-in-training is currently well in excess of the supply of New Zealand medical school graduates, it will be essential that monetary incentives are able to respond to the variations in circumstances that may occur in the medium and long term.

The present rewards for delaying entry into vocational training suggest there will be a need for doctors-in-training to receive monetary incentives to stay in training, especially after they have gained general registration and are ready to move into vocational training. Incentives need to encourage doctors to enter vocational training, taking into account the specific entry requirements of their chosen specialty.

Section 5: Links to Other Organisations Associated with Medical Education and Training

If everyone is moving forward together then success takes care of itself. (Henry Ford)

5.1 Medical Council of New Zealand (the Medical Council)

The Medical Council is responsible, under the HPCAA, for protecting the health and safety of members of the public by providing for mechanisms to ensure that medical practitioners are competent and fit to practise. The functions of the Medical Council are set out in section 108 of the HPCAA and include:

- to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies or programmes
- to authorise the registration of health practitioners under this Act, and to maintain registers
- to consider applications for annual practising certificates
- to recognise, accredit and set programmes to ensure the ongoing competence of health practitioners
- to set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession
- to promote education and training in the profession.

The METNZ would reinforce the capacity of the Medical Council as the body that sets the standards and competencies a doctor-in-training needs to have acquired prior to general and vocational registration so that the Medical Council can meet its statutory roles.²⁹

The Medical Council, via its Education Committee, currently assures these standards in several ways. It:

- accredits the medical schools to ensure the graduate doctors reach standards set by the AMC³⁰
- sets the standards for clinical placements and accredits these clinical placements via 'hospital visits'³¹

²⁹ The roles of the Medical Council under the HPCAA are to authorise registration (section 15) and prescribe and accredit qualifications (section 12), and to set and accredit ongoing competency/recertification programmes.

³⁰ In collaboration with the Medical Council, the AMC assesses basic medical courses offered by New Zealand medical schools. (AMC accreditation of these schools allows their graduates registration in Australia). The Medical Council uses the accreditation reports on Australian and New Zealand medical schools in deciding on the recognition of those schools in New Zealand. The purpose of AMC accreditation is the recognition of medical courses that produce graduates competent to practise safely and effectively under supervision as interns in both Australia and New Zealand, and with an appropriate foundation for lifelong learning and for further training in any branch of medicine. AMC accreditation is based on the medical course demonstrating that it satisfies, or will satisfy, the AMC standards for basic medical education. Accreditation standards address the requirements for delivery of high-quality medical education, including the outcomes of the medical course and the medical curriculum, assessment of student learning, monitoring and evaluation.

³¹ The Education Committee of the Medical Council organises visits and reviews of all hospitals accredited for intern training, usually every three years. Intern supervisors may ask for a hospital visit at any time. The visit is to make sure the hospital's education, supervision and facilities for interns meet the Medical Council's standards. It is the overall systems and processes that are being assessed. External reviewers are often effective in promoting positive change in clinical teams and support services. In the past the Medical Council has accredited a few general practices for intern training.

- sets the requirements for clinical placements and accredits/checks that the hospital meets these via a hospital visit process
- accredits colleges (with the AMC for Australasian colleges)³² and vocational branches
- accredits recertification (continuing professional development) programmes delivered by colleges and vocational branches so that doctors remain competent to practise.

Under the new system, METU would take the role of coordinating the training of doctors and coordinating the work of educational supervisors (previously called intern supervisors), while the Medical Council would concentrate on accrediting clinical placements and training institutions.

The coordination of clinical placements to produce the required outcome and assessment systems would be administered by METNZ.

The Medical Council would continue to strengthen its current hospital visit accreditation process in conjunction with CPMEC, who are currently working to enhance their own accreditation role. This accreditation role would go beyond the current work in relation to hospital visits and cover the accreditation of clinical placements or placements in all training institutions. Only accredited clinical placements would be allocated to doctors-in-training nationally via the IT matching system.

Eventually, the work of the CPMEC may be nationalised within the framework of the National Registration and Accreditation Scheme following the COAG³³ agreement in March 2008. This will assist the Medical Council to work closely with Australia at all levels of accreditation, as recommended by the recently released Ministry of Health review of the HPCAA (Ministry of Health 2009).

The Medical Council has the key role of setting the standards to meet HPCAA registration requirements, and is responsible for consulting on and ensuring that the domains of practice, skills and experience to be acquired in the prevocational training are completed. In doing this, the Medical Council may review the document *New Zealand Education Framework for Prevocational Training* (Medical Training Board 2008b) and the CPMEC domains of competence, and align current domains of practice with those being used by the CPMEC.

The Medical Council has published information on learning objectives, attitudes, knowledge and skills in the booklet *Education, Training and Supervision for New Doctors* (Medical Council of New Zealand 2005a), but concerns have been expressed that these skills are not always gained within the current clinical placement system. The point of emphasising building on the work already done and in conjunction with METU would be to ensure that the competencies match what is required for a doctor to be generally registered.

³² The AMC also assesses standards of specialist medical training and continuing professional development programmes; the training organisations for these programmes are national specialist medical colleges. AMC processes entail both accreditation (validating that standards are met) and peer review to promote high standards of medical education, stimulate self-analysis and assist the training organisation under review to achieve its objectives. Although this is an Australian process, the Medical Council uses AMC accreditation reports to help it to make decisions about recognising medical training programmes in New Zealand. The AMC works with the Medical Council in reviewing bi-national training programmes. All AMC accreditations are based on the training organisation demonstrating that it satisfies, or that it will satisfy, AMC standards for specialist medical education and training.

³³ Council of Australian Governments Communiqué on Intergovernmental Agreement of Healthcare Reform March 2008.

The Medical Council would need to work with the colleges and other vocational branches to ensure that at the end of the provisional registration period the doctors-in-training can be generally registered and are fit to enter vocational training.

These links in the system are summarised in the table in Appendix 10.

5.2 The Clinical Training Agency (CTA)

The CTA plays a critical role in setting medical training priorities through its role in allocating funding for postgraduate education and training. It also sets the service specifications for this training and monitors performance. The CTA seeks to maintain the integrity of medical training, but the pressures on the financial resources available to it mean that in any year it is usually able to make only marginal changes to the allocation of funds. When funds are scarce, New Zealand will occasionally need substantive shifts in approach, and the CTA cannot achieve this. The CTA also has difficulty appropriately recognising the emergence of new fields of medicine because of the nature of the funding constraints and the lack of support it has in meeting this challenge.

One of the problems is that the CTA does not have strong support to set its strategic direction. The accumulation of incremental changes it is able to make via its funding allocations and specifications makes it hard to have training funds that fit the strategic direction of the health service. Also, because the allocation of funds to the CTA is not set by the future requirements of training and service delivery, New Zealand can be slow at responding to trends in health needs and the international health market.

The METNZ Board would be an ideal governance authority to oversee CTA activity.

Without the proposed shift in governance, METNZ would not be able to be as effective as it could be in managing any required change. However, there would be some complications, because currently the CTA sits within the Ministry of Health, from which it gets direct policy advice and some infrastructural support, and so separating the organisation from the Ministry may not be the most cost-effective option. In addition, if METNZ is responsible for only medical education and training, removing this part of the CTA would require other solutions for managing funds for nursing and other professions.

5.3 The colleges and other vocational branches

The colleges and other vocational branches are crucial to the development and delivery of vocational training. They can also play a useful advisory role in prevocational training.

METNZ, METU and the national and regional directors will need to liaise closely with the colleges and vocational branches to better coordinate training and assessment across the whole education and training continuum to ensure that when doctors-in-training complete prevocational training they are fit to enter vocational training. This would include:

- encouraging the delivery of joint modules of learning between the training institutions and the colleges so that the continuum of training is well linked
- developing a database on vocational training resources and e-learning resources that could be shared
- developing clinical placements in training institutions that give an introduction to specialty training.

5.4 Other groups

METU would relate closely to other bodies, which would continue to work in their current roles, including:

- Ministry of Health (policy initiatives and advice from the Ministry of Health will be crucial for the operation of METU)
- Tertiary Education Commission (TEC)
- Ministry of Education
- Medical schools
- DHBs
- Association of Salaried Medical Specialists and the New Zealand Resident Doctors Association
- NZMA
- private hospitals, primary health organisations (PHOs) and general practices, and other institutions that have opted into being training institutions
- a wide range of other health groups in the sector.

Section 6: The Way Forward

Perpetual optimism is a force multiplier. (Colin Powell)

6.1 Implementation plan

The proposals in this report have significant implications for all those individuals and organisations currently involved in medical education and training. They would require careful consideration and management over several years. Transitional arrangements would need to be developed and put in place.

The following is an indicative implementation plan and timeline for establishing the new structure.³⁴

Stage One

Agreement in principle to proceed with options for establishment and detailed costings
Completion date: end of June 2009

Stage Two

Consultation on options with the sector
Completion date: end of September 2009

Stage Three

Final agreement and Cabinet approval to proceed with preferred option
Completion date: end of December 2009

Stage Four

Passing of legislation if required
Completion date: end of June 2010

Stage Five

Establishment of METNZ and appointment of national and regional directors
Completion date: end of September 2010

Stage Six

Implementation of national systems
Ongoing

6.2 Current funding and costs

The CTA allocates over \$93 million in postgraduate medical training. Medical post-entry clinical training (PECT)³⁵ funding is projected to increase in 2008/09 and then again in 2012/13 in line with increases in the number of medical students leaving medical school.

The challenges we face in medical education and training during prevocational and vocational training will require stronger links between the allocation of funds and other resource management issues. More training institutions will want to be involved in providing clinical placements and to have doctors-in-training in their institution. As noted in sections 4.3 and 4.7, there will need to be incentives for doctors-in-training and educational and clinical supervisors to be involved in training.

³⁴ The timeline takes April 2009, the date at which the pre-publication draft of this report was completed, as its starting point.

³⁵ PECT – post-entry clinical training funding allocated by the CTA.

With a national structure and a national governance body, there should be the potential for savings in some areas; for example, if the duplication in resource development across the country is minimised.

It is important that METNZ would be able to allocate and monitor the use of funding, and to hold training institutions providing clinical placements, educational supervisors (and educational directors) to their contracted performance agreements.

6.2.1 Prevocational training funding

Currently \$23 million is spent annually by the CTA on prevocational training.³⁶ This funding is projected to increase in 2008/09 and then again in 2012/13 in line with increases in the number of medical students leaving medical school.

Funding of \$32,190pa is allocated by the CTA to each PGY1 trainee and paid directly to the DHBs for their involvement in training, for resources, for slowdown in service provision, and to back-fill when PGY1s are in formal training.

Funding of \$19,140 is allocated by the CTA to each PGY2 and currently \$6.5 million is available for this annually.

Intern supervisors are paid a small allowance (\$740) per PGY1 and PGY2 by the Medical Council and are usually allocated one to two tenths of time by their DHB to be involved in coordinating training. The intern supervisor has a contract with the Medical Council with performance criteria. Clinical supervisors are not paid any additional money but may be allocated tenths of time by their employer to enable them to carry out the role.

6.2.2 Vocational training funding

Sixty million dollars is spent on vocational training in medicine annually from CTA resources (with some additional monies spent in psychiatry and other streams that may have an impact on medicine, such as Māori workforce development). This funding will increase due to the allocation of more vocational training places in general practice.

The CTA funds some – but not all – vocational trainees in most vocational branches. It does not fund any places in AMP and has different funding arrangements for the specialty areas of general practice and family planning. If all vocational training were funded the same way, this would have implications for the increase in funding of these three groups and for doctors who work and train in these settings.

This is an issue that will need further exploration as part of the differential in funding, and will require consideration of how best to manage that all three services have a user-pays aspect and that general practices and AMPs are essentially small private businesses. A significant proportion of their funding however comes from government to improve access by reducing patient charges. The viability of these services will be affected by increasing training obligations without commensurate increases in funding.

³⁶ CTA Purchase Intentions 2008/9.

Currently most college and vocational branch supervision work is done on a *pro bono* basis, or a small extra teaching allowance is paid. If clinical supervisors teaching doctors-in-training in prevocational training received explicit allowances for their involvement, those teaching in the vocational training area would expect similar terms and conditions. However, this does mean that these supervisors could be held more accountable for achieving any specific requirements related to training, such as attending teach-the-teacher courses.

There could be some saving made if colleges and vocational branches worked more actively together in delivering certain aspects of the training, such as communication, and if they worked better together in relation to resource development instead of each producing their own resources.

6.2.3 Costs

Due to the complexity of the environment and links between service delivery and training, careful assessment needs to be made to ensure that all costs and a realistic assessment of potential savings are taken into account, and that there are no unintended consequences or costs resulting from the changes being proposed.

Therefore, a full, detailed costing of the implementation of the infrastructure of medical education set out in this report is needed. The report proposes that the \$93 million currently allocated by the CTA could be allocated *directly* to medical education and training.

Funding and resources needed

Funding for the national and regional structure of the METNZ would include:

- support for training and resources for teachers and module development
- salary and infrastructure costs of a small organisation of approximately 25–35 people, including the regional offices (the larger number of staff would be needed if the organisation takes over the employment of all doctors-in-training)
- change management and continued consultation, and steering group work in relation to mapping clinical placements and developing an assessment blueprint
- a stocktake of resources currently being used in PGY1 and PGY2 training
- research projects and auditing
- a quality audit and evaluation of the system and the effectiveness and efficiencies of the structures after a period.

Money to improve current systems could include an information system that would be capable of:

- tracking the placement of all doctors-in-training
- listing all clinical placements, with details about their content and location in real time, and with the ability for doctors-in-training and others in the sector to access the database 'to see' where vacancies are
- providing information and resources for doctors-in-training and all trainers
- coordinating web and electronic training resources, which would be able to be accessed online.

Support for doctors-in-training may include:

- training incentives for doctors-in-training
- mentoring/career counselling of doctors-in-training
- support for doctors-in-training for remediation, when required.

Other allowances could act as incentives in the system, such as:

- allocating time for educational supervisors in each training institution to take part in the coordination of training and education (some of this would currently be paid by the DHBs)
- payments for educational supervisors in each training institution to recognise time spent in direct doctor-in-training contact (this would come direct from the METNZ instead of from the Medical Council, as happens now)
- incentives for clinical supervisors (including general practice teachers in general practice) to be trainers, paid via the DHB or other training institutions.

Local support could be provided, such as:

- education and infrastructure at accredited training institutions, some of which occurs at present
- funding for other training institutions, especially general practices, which require investment in buildings/offices so that doctors can work in these areas.

Transfers of funding would be made

The CTA could form the foundation of METNZ. (If METNZ ended up covering all health areas, the whole of CTA funding could be transferred). There would need to be a transfer of CTA staff to METNZ, or at least those CTA staff involved in medical training.

Savings should be made over time through:

- coordination of all human resource funding for doctors-in-training under one system instead of via 21 DHBs
- medical schools, colleges and vocational branches and the RNZCGP being able to use a METU database to organise clinical placements for student doctors and all doctors-in-training (in prevocational and vocational training)
- the central development of resources for training, teaching and assessment in METU instead of via multiple RMO units, as happens at present.

In time the DHBs may make locum salary savings, but this would need to be balanced against the loss of some service delivery by doctors-in-training, who in the future would concentrate more on training; for example, currently some doctors-in-training do not attend formal education sessions because they are too involved in service delivery.

The Medical Council would make some savings with respect to payment for intern supervisors – both the allowances they are paid and for the coordination of intern supervisors. However, the costs of accreditation of training institutions and clinical placements may increase. The Medical Council, and possibly the sector as a whole, would need to absorb the cost of registering students if this concept were progressed. In addition, the Medical Council would have one-off costs in relation to organising consultation about the domains of practice, skills and competencies needed by doctors-in-training.

Appendix 1: Summary of Written Submissions – January 2009

Introduction

1. Twenty-nine submissions were received in response to the Medical Training Board's (MTB) three discussion papers posted on its website in September 2008. The Board thanks all those who have made submissions and appreciates the time and effort that has gone into their preparation.
2. All submissions will be considered in their entirety but this summary attempts to highlight the key themes and issues that have been raised. It has not included all points raised and does not attempt to attribute comment to the author in all cases.
3. The Board will use the feedback that it has received in the next stage of its work which is working with the Medical Council of New Zealand on an implementation plan for the curriculum framework. Further consultation will take place before final recommendations are made.
4. The Board will also be publishing its first Annual Report at the end of March 2009. The Annual Report will be available on www.moh.govt.nz/medicaltrainingboard
5. Submitters in general agree that there are serious medical workforce issues that need to be addressed and the documents provide a base for further discussion. There is a need to establish a process for continual evaluation and change in clinical practice and medical education.
6. One submitter questioned why has it taken New Zealand medical organisations so long to recognise the need for change. Others have asked why it has taken so long for action to be taken. Hopefully the ongoing work of the Board will provide the impetus for change.

Future of the Medical Workforce

7. This document has been described as “an excellent well edited and long awaited paper of considerable interest and importance”.

Forecasting model

8. The information and data collected to date will help formulate a much clearer picture to assist in medical workforce planning. There is support for ongoing development of research and statistical analysis focusing on the future needs of the workforce.
9. However, the forecasting needs to take into account an overall reduction in the worked hours per week of trainees to reflect social change as both male and female resident medical officers (RMOs) increasingly demand work/life balance. This trend is also likely for those in vocational roles. The projected reduction of 5% in working hours for senior medical officers (SMOs) over the next 25 years is likely to be a considerable underestimate and should be revised to a higher value (perhaps 10–20%).
10. The modelling does not take account of how much work and how many hours RMOs actually do.
11. There is concern about the projected reduction of 20% in the loss rate of SMOs going overseas. How is this to be achieved? How would no reduction in this loss rate affect the projections?

12. The model needs to be regularly revisited to determine whether the assumptions continue to be appropriate, especially in view of the new Government's intention to fund an extra 200 undergraduate medical places.
13. There is a lack of international comparisons.

Medical School Intake

14. There is general support for an increase in medical school intake and the goal of net self sufficiency. Although there will always be debate about how many, the risk of too few is greater than the risk of too many. Ideally there should be no limit but this is probably not feasible in view of the substantial taxpayer subsidy.
15. The Association of Salaried Medical Specialists (ASMS) questions whether 100 (or even the new government's commitment to 200) new places will be enough in the long term. It supports an increase in GPs but does not believe that attracting a larger share of an already inadequate number of graduates to general practice and thereby decreasing the number of other specialists is a solution.
16. The flow-on costs need to be considered, for example, increases in training places, availability of supervisors, numbers of jobs, improvements to or new facilities.
17. There is support for attracting a larger share of graduates into general practice, relating medical school numbers to trainee posts for vocational training, strengthening links between medical schools, the health services and medical colleges.
18. The private sector has been glaringly underutilised in its potential to provide training. It will be essential to use it when the medical school numbers are increased. This could involve significant Government investment in infrastructure costs.
19. A criterion for entry should be "how likely is this student likely to stay in the country?".
20. Any increase in medical school numbers must be backed by an increased focus on the retention of junior doctors.
21. Because of the difficulties in recruiting and retaining doctors in academic posts, who will perform the increasing teaching and research as a consequence of increasing medical school numbers, there needs to be a path for interested RMOs to pursue academic careers without penalty.

Integrated and Coordinated Medical Training

22. One submitter commented that this paper states what most people would agree with and have been saying since the Clinical Training Agency's (CTA) report on Postgraduate Year (PGY) 2 training almost 10 years ago.
23. Another commented that this section is bland and does not face the need for reform of the health sector, especially in the hospital sector and present junior doctor situation. The term "pre vocational training" is meaningless. There is no mention of the need to rethink hospital staffing, use of clinical assistants or similar to run permanent efficient teams which would be where teaching could take place.
24. There is support for the recommendation to incorporate the best aspects of several models of medical training, including experiential learning, competency-based training, curriculum design, and having a balanced and mixed assessment portfolio.
25. The term "choke point" has negative connotations – it anticipates a problem and has the potential to create one in the minds of stakeholders.

26. The emphasis on “health service providers” ignores the education and teaching resource available in researchers, academics, managers, nurses, pharmacists and patients.
27. The last paragraph on page 3 could be paraphrased as “having bright young people in my team cheers me up” but does it efficiently and effectively educate them for the vocation they have chosen? The last paragraph on page 4 perpetuates the myth, or at least part of the original intent, that medical training would be based on the apprenticeship model. This was grossly distorted in New Zealand (NZ) when the compulsory post graduation year service in hospital was introduced in the 1950s before full registration could be obtained. What follows does not improve the situation and the use of the term pre-vocational shows a blind spot commonly held in the profession.
28. The “high quality medical graduates” are more a function of their inherent ability to survive and mature than the education system per se. Who measures this and how can we do better?
29. There is scant reference to the role of patients in clinical training; perverse motivations involved in the employment of clinical teachers by medical schools and district health boards (DHBs) may have serious impact on the timeliness and effectiveness of clinical training and the enthusiasm of clinical tutors and trainees; there is a largely untapped potential for very effective training in outpatient departments.
30. The findings of a research project based in the Faculty of Medicine, University of Otago, and funded by a University of Otago Research Grant, *The Learning Outcomes of Medical Education across the Medical Career (LOMEC)* was provided to the Board.

The Curriculum Framework

Framework

31. The concept of “waypoints” is sound (although the term is not generally used and understood) but requires further development. Is waypoint 2 necessary? Could there be posts for years 6 and 7 designated and certified by the Medical Council. While this retains the concept of time to reach each waypoint, the majority of trainees will meet the requirements in this time and a structure could be incorporated for those who need longer.
32. The NZ Medical Students Association (NZMSA) believes that a waypoint system is conceptually a good idea but may become “a logistical nightmare to administer”. If it were to be introduced, it would need to:
 - ensure that the core elements of good training were supported: experiential learning, protected teaching time, sufficient student-teacher and student-patient ratios etc
 - minimise perverse incentives
 - be simple and understandable by all members of the health care team
 - ensure that differing levels of attainment between junior doctors do not interfere with the care of patients
 - choose competency levels that are central to safe progression to the next stage of training rather than those that are easy to assess
 - align the goals of experiential and apprenticeship based learning with the skills assessed in competency based programmes.
33. The NZ Resident Doctors Association (NZRDA) believes that universities are inadequately preparing students for active practice and that a return of the trainee intern year to part-time employment would add significant benefit.

34. One suggestion is an elective clinical clerkship over summer between years 4 and 5 to improve clinical and employment skills and better prepare graduates for responsibility in year 6.
35. The use of the Australian domains of clinical management, communication and professionalism is generally appropriate although the relative merits of this and the Medical Council of NZ (MCNZ) framework could be argued.
36. There is support for incorporating both assessment of competency and the apprenticeship model but the document seems to deliver a primarily competency based framework with little reference to apprenticeship, workplace or experiential learning frameworks or models.
37. Do we need to be constrained by accreditation by the Australian Medical Council? Could set up our own institutions if there is no reasonable accommodation of our national interests.
38. The document does not elaborate on the impact of workforce issues on learning and supervision practice or attempt to incorporate viable available strategies into the design.
39. The NZ Medical Association (NZMA) questions whether the proposed system is manageable and whether the new curriculum is necessary. It would be difficult for a trainee to complete all of the requirements in the set timeframe. Are all the competencies relevant to all trainees? The level of supervision will decrease as doctors gain experience. Does New Zealand have the resources to support the new curriculum? – it will place a very high burden on SMOs in a system that is currently barely coping.
40. NZMA suggests that if current Medical Council standards were achieved by DHBs as a result of resources being increased, the majority of issues with training could be resolved.
41. Another submitter suggests that the case for examination of the PGY1–3 years is weak. A large allocation of resources is being made in order to identify the few trainees who are substandard. If the list of skill competencies was reduced from the generic catchall with a complicated series of waypoints to a shorter, run specific list of skills that could be assessed in clinically meaningful ways such as logbooks/DOPS or CBD with the supervising consultant then it would provide a focus for teaching and learning.
42. If changes are to occur, then the important components of the trainee intern year must be protected. Any changes should focus on increasing the amount of supervised clinical time and reducing time spent on paperwork and trolley pushing and retain the apprenticeship model.
43. If the undergraduate degree is reduced from six to five years then there would need to be significant planning for the double cohort of graduates in one year.
44. The Dunedin School of Medicine does not support a shortening of the current medical course and, while it supports an increase in student numbers, this alone is insufficient and emphasises that “a key to retaining students in New Zealand is an actively supportive learning environment into the RMO years, with a continuum of training”.
45. The knowledge and skill sets of vocational training specialists five years after PGY1 and 2 are extremely diverse and the need for all to have the same generic education and experience for eight years prior to entering five years of vocational training should be questioned.
46. Doctors of the future will work in multi-disciplinary teams and will need to be good communicators and “team players”. What is the optimal balance between clinical skills based training and training in communication, teamwork and non-clinical management?

47. Oral health is part of general health and appropriate observation of oral health problems would be useful in medical training. Appendix 1a should include dental caries and periodontal health.
48. There should be ongoing expertise in the specialist area of sexual and reproductive health and general practitioners (GPs) should be trained in the same scope of practice.

Implementation issues

49. The benefit of nationally coordinated arrangements for the early postgraduate years is self evident but would need to take account of the graduation date and who would employ the graduates.
50. Some believe that the trainee intern year would more effectively meet the requirements for training if it were an employment year rather than a student year. If the current years 6 and 7 were more effectively integrated, most should be competent to commence vocational training within two years.
51. If they are also required to spend more time in primary or community settings, which is generally recognised as desirable, the question arises as to who should be their employer.
52. Some aspects of vocational training will need to be conducted in private hospitals given that many simple procedures are no longer carried out in public.
53. Consolidation of primary care through large health centres is professionally, financially and economically desirable to provide learning environment in primary and community care and would achieve goals for vocational training in general practice.
54. Workplace learning with senior practitioners supervising, coaching and teaching the novice must be retained. Do not want the perpetuation of the student role with “tick boxes” without concurrent emphasis on workplace learning. Learning needs to prepare people for ongoing demands of continuing education and prepare learners for the level of self and peer assessment required to participate in CME activities and monitor personal; performance and competence throughout their career.
55. There needs to be recognition of the formal and informal training currently undertaken by DHBs and the role of intern supervisors and consultant supervisors and MCNZ’s current assessment processes.
56. Importance of internship as a transition period needs to be recognised. The GMC (2005) states two main goals for medical graduates: to practise applying undergraduate knowledge and skill and to make the transition, under clinical and educational supervision, from provisional to full registration.
57. There should be no element of compulsion as to where RMOs are deployed, for example, to address maldistribution issues.
58. Lessons from the United Kingdom (UK) must be incorporated in any implementation plan.
59. The progression from PGY1 to beginning vocational training has been given undue importance, little to illustrate that trying to rush doctors into junior trainee roles is beneficial to the health system or individuals. The criticism of Modernising Medical careers (MMC) included the point that not all Foundation Year 2 doctors had decided on vocational training paths. Putting an arbitrary 4 year cap on this contradicts the aim of a pluripotent doctor.
60. Although the concept of the curriculum is useful, there is no indication of how the skills and attitudes will be achieved.

National body

61. The early establishment of a National Directorate and the appointment of a National Director is seen by some as a key success factor to realising the strengths of the MTB's discussion documents
62. Others see that a national training directorate with regional centres has merit but the governance body needs to include DHBs, medical education units within hospitals and the Medical Council. Also essential that it include representatives of the medical colleges.
63. Another considers that a national body may be a good idea but it could easily become "the addition of another layer of bureaucracy and cost to New Zealand's current health workforce and training systems, without any off-setting reduction in existing bureaucracy or productivity gain".
64. NZRDA does not consider that there is a need for a central committee to assess the information and predictors and their effect on future workforce numbers. The Ministry of Health should produce workforce data and establish a non political ombudsman type arrangement to provide audit, review and make recommendations as they see fit. The CTA should be disestablished and the funds returned to the DHBs to deliver on initiatives to retain this essential workforce.
65. NZMA agrees that national consistency in training, education and service delivery are important, as is seamless transition from one area to another, but questions whether the creation of a national training body is necessary to achieve this.
66. The Dunedin School of Medicine supports the concept of a National Directorate.
67. Continuing the model of employment by hospitals restricts flexibility. If the national body were to employ all trainees, the issue of who would employ them in primary care settings would be resolved. Hospitals and primary health organisations (PHOs) could still employ non-trainees directly.
68. A single national employer would also facilitate a national employment agreement that facilitates training, accepts a limitation on working hours and protects training requirements and flexibility of placement.
69. NZRDA considers that there should be improved integration of general practice with the DHB hospital based experience. To facilitate this, the employment of resident doctors in general practice should be the responsibility of the DHBs and all service recognised as continuous.

Links to vocational training programmes

70. One submitter suggests ways of accelerating the production of vocationally trained doctors should be considered – options for more innovative restructuring of medical training, introducing much earlier streaming into vocational training for some specialties and reducing the proportion of doctors with what is now at least eight years of mandatory "generic" education and experience.
71. The submissions of individual colleges are summarised below.

Physicians

72. The curriculum framework presents a number of opportunities for close alignment with the existing plans for the Royal Australasian College of Physicians' (RACP) Physician Readiness for Expert Practice (PREP) program. The approach of integration of teaching and learning tools and formative assessment is nearly identical to that in the PREP program.

73. An advantage of this is that there will be acceptance at all levels of training for the need for such ongoing workplace assessment and greater recognition of the resources required and integration of such increased supervision into the DHB service provision environment.
74. Another advantage is that such assessment tools being undertaken by trainees are easily measurable and could provide appropriate use of CTA funding.
75. The key domains of the proposed curriculum are aligned with the existing curricula of the RACP.
76. The oversight provided by the college for basic and advanced training encompasses waypoints 3 through 6. If the PREP program was available to trainees in the current PGY2, waypoints 2 and 3 would become a single waypoint for trainees entering at that level. If the MTB proposals go ahead, it would encourage trainees to enter the PREP program at PGY2 level and begin vocational training then. The issue of recognition of prior learning would need to be addressed. There will need to be dialogue between the college and the MTB to avoid duplication of training.

Intensive care medicine

77. The NZ National Committee supports the idea of formalising PGY1 and PGY2 (generalist years) with waypoints/assessment of competencies but not direct entry to vocational training.

Surgeons

78. The Royal Australasian College of Surgeons makes the following key points and looks forward to further development of the draft proposals:
 - On junior medical staff employment – “There is an urgent need to examine and change the role of junior medical staff in our hospitals. Without significant change PGY1 and PGY2 will remain a period of relatively limited clinical exposure resulting in an unnecessarily slow accumulation of skill and experience”.
 - On duration of training – “Recognising the current limitations of the present undergraduate and postgraduate education and experience the New Zealand National Board of the Royal Australasian College of Surgeons is strongly opposed to any shortening of the period of training”.
 - On the proposed medical curriculum:
 - “While such a programme is to be applauded, it is important that the level of skill to be acquired is more critically considered. The goal is the achievement of a broad knowledge base and the skills to enable the smooth transition into any specialist training programme where more specific and higher level skills would be developed.”
 - “The development of a structured and coordinated programme as outlined will require the commitment of considerable resources to supervise and mentor. This is likely to be costly – both financially and in clinical time. The resources to support the curriculum need to be in place before it is implemented.”
 - “The trainee intern year is seen by the Royal Australasian College of Surgeons as a valuable transitional year and should be recognised as such and retained.”
 - The need for additional general practice exposure should not come at the cost of delaying progress into other specialty training programmes.
 - On the apprenticeship model – “Apprenticeships remains a fundamental feature of the surgical training programmes. Problem evaluation, critical thinking, refinement of surgical technique and the development of good judgment are all fostered in this environment”.

- On workforce distribution – “Considerable work is required to create better working environments and attractive employment packages to attract and retain appropriately trained practitioners in provincial centres”.

Anaesthetists

79. The New Zealand National Committee of the Australian and NZ College of Anaesthetists (ANZCA) supports many of the proposals outlined in the discussion documents and comments on specific issues that impact on anaesthesia and the perioperative team. It comments:

- Anaesthesia requires general experience in medicine and surgery in the transition years.
- The College would be concerned if the length of post graduate training was reduced.
- The College supports the proposal to increase trainee numbers and is currently reviewing its curriculum with this in mind.
- The increase in numbers will result in an increased need for a variety of resources to be available to support trainees and trainers (including infrastructure and availability of time for quality supervision).
- The College is currently reviewing its FANZCA training program and will ensure that the MTB proposals are considered in this process.
- The apprenticeship-style education and training which doctors experience has many benefits. There are certain core competencies that should be assessed and passed but clinical experience is also needed. The knowledge, skills and professional attitudes that are required need to be broad-based.
- To understand what education and training is required and to work effectively within the clinical care system in New Zealand, it is necessary to grasp the essence of medical professionalism.
- It quotes Don Berwick – “train your health care workforce for the future, not the past. That workforce needs to master a whole new set of skills relevant to the leadership of and citizenship in the improvement of health care as a system – patient safety, continual improvement, teamwork, measurement and patient centred care to name a few”.
- Providing sufficient, quality time for interaction between the students/trainees and their teachers/supervisors is very important as is feedback to students and trainees. ANZCA is undertaking a full-scale review of the teacher training and support it provides for all those with responsibility for the education and day-to-day supervision of its trainees.
- It supports Simulation and Clinical Skills Centres, flexibility within training programmes training, training exposure in rural and provincial areas, more Māori and Pacific medical students, working in health care teams, improving data collection, the move to self sufficiency.

Psychiatrists

80. The Royal Australian and NZ College of Psychiatrists (RANZCP) supports:

- increased numbers of medical students and recognises the value of managing distributions by considering the numbers entering each vocational branch. Need to consider how current service delivery needs of each specialty/vocational branch are being met by numbers entering training, and how this balance is expected to shift in the future

- attracting a greater share of medical school entrants into primary care as this is an essential avenue for people to access secondary mental health and addiction services. But attention also needs to be directed toward areas such as developing communication and liaison with secondary/specialist services and ensuring appropriate training and opportunities in areas such as mental health are made available to GPs
 - linkages between the medical schools, health services and medical colleges as effective linkages and relationships will be an essential part of resolving training and workforce issues and managing the needs of both training and service delivery
 - encouraging greater numbers of Māori and Pacific students into studying sciences at secondary school
 - improving current processes for doctors in the prevocational years and more adequately measuring competence to practise.
81. The College is moving to adopt the Canmeds framework rather than the Australian Junior Doctor Curriculum Framework.

General practitioners

82. The Royal NZ College of General Practitioners (RNZCGP) is very supportive of the work/general direction of the MTB In particular:
- the emphasis on general practice and especially the need to encourage a greater proportion of medical graduates to enter the specialty of general practice
 - the support for all medical students to gain experience of general practice and acquire some understanding of the skills, knowledge and attitudes required in this specialty
 - recognition of New Zealand's dependence on international medical graduates and partly trained (generally registered) doctors and the problems that creates
 - plans to increase the number of medical school places. This will create a need for a corresponding increase in the number of vocational training places
 - recognition of the need for investment in plant to enable an increase in training in general practice
 - recognition of the need to train and support teachers – which the RNZCGP incorporates as an inherent part of its training programme and in this respect is well advanced of many of the other specialty training programmes
 - the proposal to introduce national coordination of training but the college would like clarification of the interface between and respective roles of a national training body and the RNZCGP general practice education programme
 - recognition of the problems created by the lack of a governance body for the CTA, and the appreciation of the need to remedy this void
 - the importance placed on doctors having a robust general base prior to specialisation. A good general grounding makes the profession more resilient and easily able to change to meet service needs demands
 - the move away from over-reliance on time-based progression
 - the moves towards the increased educational rigour that will result from having a curriculum for the prevocational years. The College is concerned that the current training system is geared towards service delivery, not training. The focus on training is a strength of the College GP training programme.

Training in provincial centres

83. There is a difference of view about medical training in the provincial centres from that in the main cities. Tairāwhiti DHB, for example, supports the view that all doctors should be generalist trained but considers that the future of generalist/specialist training must include attachments to, and possibly be centred on, provincial DHBs.
84. There is a broad range of practice in provincial centres: true generalism, as there are no subspecialty groups and generalists are expected to (and do) a range of subspecialty care. Best junior training occurs in smaller, usually provincial, hospitals where there are fewer middle grade staff to do the “exciting” work.
85. There is a good relationship between the hospital and local GPs with GP training set up to go, restricted only by limited resources.
86. Another submitter commented that the primary way to ensure voluntary moves of junior doctors to small urban and rural centres is to ensure a stable workforce of senior doctors in these locations.

Māori/Pacific

87. Recognition that Māori and Pacific peoples are under represented in the medical profession is welcome although some believe that the changing health demographic in relation to Māori and Māori health is not reflected in the framework.

Other roles

88. The Board of Studies (Medical Programme), University of Auckland, comments that the documents lack a coherent vision of the role of the doctor in the medium term future. Notwithstanding any other changes, doctors of the future, by training and aptitude will be the health care workers with:
 - the cognitive and intellectual ability to diagnose patient illnesses, then develop and communicate management plans
 - the ability to make sound professional judgments and help others to cope where there is clinical uncertainty
 - the ability to take responsibility for patient management, including when tasks have been transferred to others
 - a scientific and innovative approach to clinical problems and issues with health care delivery.
89. If this is the case, more routine aspects of health care must be devolved to others, with doctors deployed on those tasks more in accord with ability, level of training and investment. In other words, “you don’t need a Rolls Royce to deliver the milk”.
90. The consultation documents from the MTB, including the outlined numbers needed in undergraduate medical programmes, appear to be predicated on the continuation of the current scope of medical practice. We (*Board of Studies*) believe that future complementary roles may be needed to support the future role of a medical practitioner; not take over the cognitive work needed to plan and provide optimal health care. While this may have been beyond the brief of the MTB, it is anticipated that attention to this visionary aspect will be part of a future work stream. Without this vital work, any curriculum and its management may be limited in terms of what it can achieve.
91. The NZ Nurses Organisation supports the development of integrated and coordinated medical training but suggests that the minimal reference to roles undertaken by nurses, midwives and others in patient care and medical training indicates that insufficient

attention has been given to the development of appropriate professional relationships and collaboration. Establishing commonality where scopes of practice overlap have been overlooked and they recommend that consideration be given to integrating credentialing to establish universal standards of competence to practise within a specific work environment.

92. NZMA supports nurses and allied health staff working in expanded roles based on a set of principles but would be cautious about role/substitution as a resolution to medical practitioner shortages.
93. The Chief Medical Advisor at Northland DHB comments:

“Hospitals do need health professionals to perform the sorts of tasks undertaken by the PGY1 and PGY2 doctors, but it is not clear why these roles should be performed for just 2–3 years by this particular workforce who will never do it again. A better service might, in fact, be provided if the PGY1/2 role were made a career, which could be combined with general practice; this is a model used in some of New Zealand’s smaller peripheral hospitals where GPs combine work in general practice with hospital roles. The role of the PGY1/2 doctor currently is much more like the role of a GP in a hospital than like the role of the consultants to whom they are supposed to be “apprenticed.” Another alternative might be for it to become a “physician assistant” role for a new type of health professional. This may be a key issue in concerns about the experience and training of doctors in those postgraduate, pre-vocational years. Some competencies related to their PGY1/2 roles are ones which they will not use in their later vocational roles (and which they should preferably have acquired before they commence work in the PGY1/2 roles); some of the more generic competencies, particularly in the Communication and Professionalism domains, would be better developed up to the Expert level during the vocational training years, which are true apprenticeships.”

Graduate entry

94. There is some support for graduate entry to medical schools. One submitter believes that it should be made mandatory if it is to become a reality.

Code of Health and Disability Services Consumers’ Rights

95. The Health and Disability Commissioner notes two particular areas where there is an interface between medical training and the Code – informed consent and supervisory arrangements.

Other issues

96. IHC is concerned that the health needs of people with an intellectual disability do not form any part of medical education in New Zealand. Their needs should be an integral part of undergraduate medical education and subsequent clinical training, both general and specialist.
97. If the medical doctor were to learn something about psychosomatic healing, it could cut down a lot of his/her training time therefore increasing the production of the workforce and doctor’s ability to handle the field of psychosomatic illness.
98. ASMS provided the Board with a copy of its submission to the Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers employed by DHBs *“Repairing the ‘leaking bucket’*.

Appendix 2: Glossary

CETU (Clinical and Education Training Unit): provides medical education for junior doctors and international medical graduates for the Auckland District Health Board.

Clinical placement, or run: the term used to describe the placement of the doctor-in-training in an area of the hospital. Currently it is usually three months' duration. The clinical placement should give an overall educational experience and enable the doctor-in-training to have access to seniors who provide supervision, assessment and feedback. Clinical placements are also sometimes called rotations.

CME (continuing medical education): ongoing educational activities and learning to help medical practitioners maintain competence.

Colleges and vocational branches: the professional educational colleges and vocational branches that are recognised by the Medical Council.

Competencies: the attitudes, skills, knowledge and behaviour required by health practitioners and support workers to perform particular functions.

Continuity of care: people are able to access needed services at the right time, in the right place and from the right people.

CPD (continuing professional development): the systematic updating of skills, knowledge and competence that takes place throughout a working life.

CPMEC (Confederation of Postgraduate Medical Education Councils): an association of postgraduate medical councils from each state or territory in Australia.

CTA (Clinical Training Agency): a unit within the Ministry of Health that funds post-entry clinical training in order to facilitate the development of the health and disability workforce.

DHB (district health board): a funder and provider of publicly funded health services for a specific geographic area. Twenty-one DHBs were established under the New Zealand Public Health and Disability Act 2000.

DHBNZ (District Health Boards New Zealand): an organisation that represents all DHBs.

Doctors-in-training: used in this report to refer to all doctors who have graduated from a medical school and who are in formal training. There are two distinct groups of doctors-in-training:

- *prevocational doctors-in-training*, who gain their training through being in clinical placements and have not yet entered a vocational training programme
- *vocational doctors-in-training* or training registrars, who have been accepted into specialty training.

General scope of practice: a doctor who has completed the requirements of a provisional general scope can be registered within a general scope of practice. Examples are junior doctors who have completed their first postgraduate year and may be in vocational training; doctors who have not started, or have chosen not to do, vocational training; and doctors nearing retirement who are no longer meeting the requirements for registration within a vocational scope of practice. A doctor registered within the general scope of practice must establish a collegial relationship with another doctor who is registered within the same or related vocational scope, and must participate in appropriate continuing professional development to maintain and improve competence and be recertified each year.

Generalist training: the document *Training the Medical Workforce 2006 and Beyond* (Ministry of Health 2006)³⁷ noted that: 'it is a widely held view that generalist skills at an appropriate level should be recognised as desirable for all doctors. Such skills need to be supported by training programmes that fit clinicians to this type of service provision. Generalist skills are also the central tenet of general practice and high-quality opportunities for training in these skills need to be retained and enhanced'. The Roundtable placed high value on the core skills of the generalist, particularly in smaller hospitals providing a wide range of core services and in remote and rural areas.

³⁷ This report was compiled by the Doctors in Training Workforce Roundtable (the Roundtable), established in 2004 to address issues relating to the clinical training of junior doctors, the relationship with undergraduate medical education, and the environment that supports the development of the trained workforce.

These core skills:

- are central to assuring holistic care of the patient, particularly as individual case complexity increases
- bring the necessary flexibility to respond to changing demands
- increase the scope for movement between specialties
- support the recognition of different roles in intermediate care.

House officer: a medical graduate employed in hospital environments in the first or second postgraduate years; also called a resident medical officer (RMO). Senior house officers are in their third or subsequent postgraduate year.

HPCAA (Health Practitioners Competence Assurance Act 2003): legislation designed to protect the health and safety of the New Zealand public by ensuring health practitioners are competent and fit to practise within their scope of practice.

Intern supervisors: these are nominated by the District Health Board's chief executive officer. The Medical Council approves the person and has a contract with them. The intern supervisor fulfils their role and responsibilities for the education, training and supervision of interns.

International medical graduates (IMGs): sometimes called overseas-trained doctors (OTDs), these are doctors who obtained their primary medical qualification in a country other than New Zealand. This term excludes temporary doctors.

Locums: doctors who choose short-term employment by more than one DHB rather than permanent employment with one DHB.

Medical Council of New Zealand: the Medical Council registers doctors to practise medicine within their scopes of practice in New Zealand.

Medical officers: posts targeted at those who have sufficient training to act in a senior role but lack formal completion of training that would allow vocational registration as a specialist; in a pay scale is called a MOSS doctor.

METU (Medical Education and Training Unit): the unit of the proposed METNZ which would coordinate medical education and training, give policy and contract advice, and ensure funding is allocated in accordance with the strategic direction of the METNZ.

METNZ (Medical Education and Training New Zealand): the new organisation being proposed to coordinate medical education and training.

Models of care: an approach for developing service delivery in relation to particular patient needs (eg, developing service components required by individuals with diabetes).

MTB (Medical Training Board): established in 2007 to provide strategic overview of medical education and training.

National director of medical education and training (national director): the proposed director or senior manager of METU.

New Zealand Health Strategy: an overall framework for the health sector, with the aim of directing health services at those areas that will ensure the greatest benefits for our population, focusing in particular on tackling inequalities in health.

Non-government organisations (NGOs): these encompass community or voluntary organisations; Māori, iwi and hapū organisations; and for-profit organisations which government organisations contract with for the delivery of outputs.

Nurse practitioners: experts in their field who use advanced knowledge and skills within their specialist scope of practice. Nurse practitioners are educated through a clinically focused masters degree programme and must meet the competencies set out by the Nursing Council of New Zealand. These include being able to articulate and advance the scope of their nursing practice, showing expert practice, and working collaboratively with other disciplines as well as across settings.

PGY1: a doctor-in-training in their first year after graduation – postgraduate year 1. These doctors are expected to be supervised, complete a number of specific runs and attend formal education sessions.

The Medical Council also puts restrictions on matters such as when the doctor may work nights, in emergency departments, or take informed consent.

PGY2: a doctor who is in their second year out from graduation – postgraduate year 2. There is no formal standardised training contracted with the Clinical Training Agency for this group, even though it is widely held that these doctors should still be in some type of training.

Population health: the health of groups, families and communities. Locality, biological criteria (such as age or gender), social criteria (such as socioeconomic status) or cultural criteria (such as whānau) may define a population.

Portfolio: a tool for doctors-in-training that could be the record of learning, or 'portfolio', so that they are encouraged to take control of their own learning and development and can demonstrate what competencies and skills they have achieved. This is similar to the current *Training Record* produced by the CETU. The introduction of the *Training Record* notes that it designed to:

- develop good habits of self-reflective learning
- assist in the documentation needs for registration and continuing professional development
- act as a repository for learning and achievements when applying to a vocational training programme.

In the UK the Foundation Programme has a detailed guide on how a doctor-in-training can use their portfolio so that they will understand the areas they need to cover during their Foundation Programme, and the standards that will be expected.

Primary health care: essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.

Primary health organisations (PHOs): local, not-for-profit provider organisations funded by DHBs to provide primary health care services to an enrolled population.

Primary/secondary interface: the connection between primary and secondary health care. Better communication and teamwork between primary and secondary health care ensures that the knowledge and skills of both are applied to each patient's care in the most effective way.

Professional colleges: organisations that are authorised to register vocationally qualified medical practitioners.

Provisional general scope: all newly registered doctors must work under supervision for at least 12 months. During this time they are registered within a provisional general scope of practice and their performance is assessed by senior colleagues. They must complete certain requirements to be registered within a general scope. New Zealand and Australian graduates who have already completed their internship in Australia are exempt from working under supervision for 12 months.

Provisional vocational scope: doctors who have completed their vocational training and who are not already registered in New Zealand must work under supervision for at least 12 months. They are registered within a provisional vocational scope of practice. During this time they must complete the Medical Council's requirements for registration in a vocational scope. Those requirements may include working in a formal assessment position and/or passing an examination.

Regional directors of medical education and training: the senior managers at a regional level of the proposed structure.

Registrar: this term strictly refers to a work role. Most practitioners employed in these roles are undergoing postgraduate specialist training in posts approved by the vocational colleges.

RETU (regional education and training unit): the regional arm of METU.

RMO (resident medical officer): a term that covers house officers and registrars. RMOs are doctors-in-training.

Scopes of practice: health services that a practitioner is qualified and competent to offer, the parameters within which these services can be offered, and a time period for review.

Secondary health care services: specialist services that patients access when their needs are unable to be met by primary health care services. These are typically provided in a hospital setting.

TEC (Tertiary Education Commission): a stand-alone Crown entity responsible for implementing the government's relationship with the tertiary education sector and for policy development and implementation.

Vocational branch: a specialist college, society or association accredited by the Medical Council. It usually delivers vocational training, and a doctor who has completed this training successfully gains vocational registration. Most vocational branches are linked to colleges, the exceptions being accident and medical practice (AMP), family planning and musculoskeletal medicine.

Vocational registration: a general practitioner or specialist who has met the criteria for registration as a 'specialist' with the Medical Council of New Zealand, including completion of the requirements of the relevant college or professional association.

Vocational scope of practice: a doctor who has completed his or her vocational training as a consultant and has appropriate qualifications and experience can be registered within a vocational scope of practice. There are 35 vocational scopes recognised by the Medical Council. A doctor registered in a vocational scope must participate in an approved continuing professional development programme to maintain competence and be recertified each year.

Vocational training: the training registrar works in a *training post* within a specific specialty. Training in vocational or specialist areas is organised via the professional colleges and vocational branches: they set the programme, accredit training posts and approve supervisors.

Workforce development: any initiative that influences entry to and exit from the health and disability sectors, including education, training, skills, attitudes, rewards and the associated infrastructure.

Appendix 3: Possible Continuum of Education and Training from Medical School to Specialist

Respondents to the *Curriculum Framework* document had difficulty visualising how any new system may work. The following table gives a comparison of current and future possible systems, taking into account the waypoints detailed in the curriculum document. The proposed new structure is set out on the right-hand side of the table and aligns with the current system on the left. The key difference is that **time spent on each stage does not align**.

Current "milestones" which are time linked			New waypoints that are not time linked		
Medical school student (1 year pre-entry or graduate entry; 5 years in medical school)	Components (outcome/competency-based)	Assessment methods/ responsibility of	Medical school student (including possible graduate entry)	Components Move to outcome/ competency base in same framework as in doctor-in-training (DIT) years	Milestone and assessment and responsibility
Pre-entry	Health sciences	Responsible to the medical school Has a combination of course work, in course assessment and examination. Year five has to be passed overall.	Year one	Further integration of foundation sciences in clinical learning (Clinical clerkships over summer electives at the end of years 3 and 4 with an overseas elective possible at the end of year five could be advantageous) ³⁸ There would be increasing focus on clinical skill acquisition and professional competencies to be a doctor.	The medical schools, in consultation with the Medical Council and the METU on competencies and skills to be gained by the end of year five. The MBChB will be conferred by the medical school at waypoint one and then the doctor can apply for provisional registration The medical school assesses doctor is capable of clinical practise in hospital settings when it grants the MBChB ie needs to be competent to be DIT not a trainee intern (TI).
Year two	Health sciences, fundamentals of clinical practice, professional practice		Year two		
Year three	Health sciences, fundamentals of clinical practice, professional practice		Year three		
Year four	Increasing emphasis on clinical practice in context – in hospitals and the community		Year four		
Year five	Emphasis on clinical practice and competence in context – in hospitals and the community 40% of assessment in course, 60% examination.		Year five: A clinical clerkship over summer elective could be advantageous End of year five or later		
Throughout there is a vertical integration of early clinical contact, clinical skill acquisition self directed learning, case-based learning, evidence based medicine, Hauora Māori professional development and ethics, research and critical appraisal and population health.			Waypoint one Medical School in conjunction with METU and Medical Council assesses doctor is capable of clinical practise in hospital settings and granting of a provisional form of registration is acceptable – this would be similar to assessment at end of year five examination – ie, waypoint one – entry to prevocational training (Category 1 DIT). Gains provisional registration -now a novice moving to novice expert.		

³⁸ TI year does give options for overseas elective etc and valuable experience and exposure that may be lost with no TI year.

Current "milestones" which are time linked		
Medical school student (1 year pre-entry or graduate entry; 5 years in medical school)	Components (outcome/competency-based)	Assessment methods/responsibility of
Trainee intern	<p>Unique to New Zealand – allows for supervised transition between student and being an intern</p> <p>Tends to be observationally based and the TI year gives an over view of the work of a SMO rather than preparation for a house officer (HO) role</p> <p>Does allow for electives in any country</p>	The Bachelor of Medicine and Surgery MBChB is conferred at the end of the TI year – awarded by the Medical school
PGY1/Intern	Gain provisional registration in a general scope	<p>Is responsibility of DHB and Medical Council</p> <p>Currently signed off by intern supervisor (who reports to the Medical Council) at end of each run and within each run by consultant</p> <p>Minimum 46 weeks in runs:</p> <ul style="list-style-type: none"> • one category A medical • one category A surgical • and two others
PGY2/3,4 House officer	<p>Now registered in a general scope</p> <p>Primary in service delivery/still rotate in runs/little formal training</p>	Some training but not consistent across the country
Training registrar Year 9 and 10?	<p>Basic vocational training</p> <p>Sit and pass part one or PRIMEX</p>	
Advanced – vocational training Years 10/11–15	Fellowship plus registration in a vocational scope	
Specialist or registered within a vocational scope Awarded Fellowship	Currently meet Medical Council requirement for recertification to get next annual practicing certificate (APC)	College sets requirements for recertification and maintaining competency as accredited by Medical Council/AMC

New waypoints that are not time linked		
Medical school student (including possible graduate entry)	Components Move to outcome/competency base in same framework as in doctor-in-training (DIT) years	Milestone and assessment and responsibility
DIT/RMO – 1 Needs close supervision – face to face and hourly Works in closely supervised controlled and clinical settings	<p>Cannot work unless supervise in emergency department (ED) or at nights</p> <p>Should have medical and surgical exposure</p> <p>Must have time spent in formal learning activities</p> <p>Limited prescribing, and may request limited range of significant investigations</p>	<p>Responsibility now of the METU and DHB/training institution working to competencies set by Medical Council</p> <p>Has provisional registration</p> <p>In general is a novice moving to expert novice</p> <p>Must be at this stage least nine month and no more than two years</p>
<p>Waypoint two</p> <p>To move on has an "overall performance assessment" with multi-source feedback to ensures DIT is competent and has experience to progress to working nights, do a wider range of work etc.</p> <p>Now an expert novice moving to competency.</p>		
DIT/RMO – 2 Does not need such close supervision Face to face daily contact with supervisor Can be supervised by phone / 24 hour review of cases Works as part of the team Cannot discharge/supervisor must review plan	<p>More involvement in service provision – greater than time in formal learning</p> <p>Do period in a provincial/secondary hospital</p> <p>Do some work in private hospital</p> <p>Do some period in ED/AMP</p> <p>Do a period in a PHO</p> <p>Can do nights without direct supervision</p> <p>Can do informed consent for all procedures</p> <p>Can do nights if senior available</p> <p>Does consent on non interventional or minor procedures</p>	<p>Responsibility now of the METU and DHB/training institution</p> <p>Needs input of council on competencies to be achieved and assessment systems as at end of this period will gain general registration</p> <p>Needs input of colleges and need to be able to move into college training programmes</p> <p>Must be at this stage at least nine months and no more than two years</p> <p>This is the opportunity to "sample" specialities/other work areas</p>

New waypoints that are not time linked		
Medical school student (including possible graduate entry)	Components Move to outcome/ competency base in same framework as in DIT years	Milestone and assessment and responsibility
<p>Waypoint three</p> <p>Responsibility now of the METU working in conjunction with colleges as will enter vocational training.</p> <p>To move on has a “performance assessment” with multi-source feedback to ensures DIT is competent and has experience to progress and gain general registration.</p> <p>Now considered “competent”.</p>		
<p>DIT/RMO – 3</p> <p>Able to operate independently and start training in specialty area</p>	<p>Should move into specialty training – if not must be in a CPD programme to gain Medical Council recertification</p>	<p>Responsibility now of the METU working in conjunction with colleges.</p> <p>Medical Council involvement because at the end of this point will get vocational registration</p>
<p>Waypoint four</p> <p>Responsibility now of the METU working in conjunction colleges and council as will exit with vocational registration and possibly Fellowship.</p> <p>To move on has colleges’ exit exam.</p> <p>Now proficient in specialty area.</p>		
<p>DIT 4</p> <p>Able to operate work independently specialty area</p>	<p>Maintaining professional competency</p>	<p>Is vocationally registered</p> <p>Have 3–5 yearly performance assessment to keep APC</p>

Appendix 4: Role of the Doctor from the United Kingdom Work

Note: DHBNZ also continues to do work on these definitions and designations of roles.

Sir John Tooke's Inquiry into Modernising Medical Careers (Modernising Medical Careers Inquiry 2008) called for the profession to speak with a coherent voice and to define the role of the doctor. The profession heeded that call. This is the current consensus on the ever-evolving role of the doctor. It has been developed in consultation with the undersigned organisations, patient groups and those medical and lay delegates who attended the Role of the Doctor Conference in October. The statement builds on much recent work by the signatory organisations and should be seen in the context of the Duties of a Doctor, as defined by the GMC in Good Medical Practice (General Medical Council 2006).

The consensus statement on the role of the doctor³⁹

Doctors alone amongst health care professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well-developed clinical judgement. The doctor's role must be defined by what is in the best interest of patients and of the population served.

Based on the definition of the role of a medical doctor proposed by the International Labour Organisation,⁴⁰ it is agreed that:

Doctors as clinical scientists apply the principles and procedures of medicine to prevent, diagnose, care for and treat patients with illness, disease and injury and to maintain physical and mental health. They supervise the implementation of care and treatment plans by others in the health care team and conduct medical education and research.

All health care professionals require a set of generic attributes to merit the trust of patients that underpins the therapeutic relationship. These qualities include good communication skills, the ability to work as part of a team, non-judgemental behaviour, empathy and integrity. In addition to possessing these shared attributes doctors must be able to:

- assess patients' health care needs, taking into account their personal and social circumstances
- apply their knowledge and skills to synthesise information from a variety of sources in order to reach the best available diagnosis **and understanding** of the patient's problem, or to know what steps need to be taken to secure such an outcome
- support patients in understanding their condition and what they might expect, including in those circumstances when patients present with symptoms that could have several causes
- identify and advise on appropriate treatment options or preventive measures
- explain and discuss the risks, benefits and uncertainties of various tests and treatments and where possible support patients to make decisions about their own care.

³⁹ In this statement 'doctor' refers to all qualified doctors, including those in training.

⁴⁰ Adapted from the definition of a medical doctor in *International Standard Classification of Occupations (ISCO), Draft ISCO- 08 Group Definitions Occupations in Health*, <http://www.ilo.org/public/english/bureau/stat/isco/draftdoc.htm>

The nature of these core requirements emphasises the need to select those with the appropriate attributes for training. Medical undergraduate education must provide a strong grounding in relevant science and in clinical practice, as well as providing opportunities to develop an appreciation for research. Doctors must have the ability to assimilate new knowledge critically, have strong intellectual skills and grasp of scientific principles and be capable of dealing effectively with and of managing uncertainty, ambiguity and complexity. They must have the capacity to work out solutions from first principles when the pattern does not fit. All doctors must be demonstrably committed to reflective practice, monitoring their contribution and working continually to improve their own and their team's performance. Doctors must all be committed to playing a part in the education and support of the next generation of medical practitioners and facilitating the advancement of evidence-based practice.

The doctor needs to be capable of assessing and managing risk; this requires high-level decision-making skills and the ability to work outside defined protocols when circumstances demand. Doctors must also be able to make informed decisions about when supportive care is more appropriate for the patient than intervention.

The doctor must possess the ability to work effectively as a member of a health care team, recognising and respecting the skills and attributes of other professions and of patients. Patients with long-term and disabling conditions are particularly likely to be experts in their own condition and should be supported to keep as healthy and independent as possible.

All doctors have a role in the maintenance and promotion of population health, through evidence-based practice. Some will enhance the health of the population through taking on roles in health education or research, service improvement and re-design, in public health and through health advocacy.

Notwithstanding the primacy of the individual doctor–patient relationship, the doctor must appreciate the needs of the patient in the context of the wider health needs of the population. For all doctors the patient must come first, but they will achieve this in different ways and in different settings. As the critical decision-maker with responsibility for significant health resources the doctor must be capable of both management and leadership and of taking ultimate responsibility for clinical decisions. Within a world where the capacity to treat is growing but financial resources are finite, doctors have a duty to use resources wisely and effectively and engage in constructive debate about such use. They should ensure that their own and others' skills and knowledge are deployed to best possible effect.

Doctors have a key role in enhancing clinical services through their positions of responsibility. Some will move on from clinical leadership and management to leadership roles within organisations at various levels – service, institutional, national and international.

The role of the doctor is changing and will continue to change alongside the needs and expectations of patients. Patients are increasingly better informed and act as partners in their own health care. The doctor serves as advisor, interpreter and supporter in this endeavour.

This statement has the support of: The Chief Medical Officers of England, Scotland, Wales and Northern Ireland; the Academy of Medical Royal Colleges; the Association of UK University Hospitals; the British Medical Association; the Conference of Postgraduate Deans; the General Medical Council; the King's Fund; the Medical Schools Council; NHS employers; and the Postgraduate Medical Education Training Board.

Appendix 5: Progress Through the Training Continuum and the Links to Registration

Pathway	Scope of practice	Parameters of scope	Responsibilities
Student doctors linked primarily to medical school	Student scope, possibly with conditions restricting any independent action in relation to patients by the student	The student scope would link registration to being an enrolled student in a New Zealand-accredited education programme and at an accredited school of medicine. The student would not be allowed to take part in any independent practice with patients, and in these cases must work with a fully registered doctor. The Annual Practising Certificate (APC) could have conditions stating these limitations.	The medical schools in consultation with the Medical Council would assess fitness to register. Annually the medical school would assess that the student doctor is capable of working in hospital settings as part of a team and under the supervision of a fully registered doctor, and that an APC could be granted.
Doctor-in-training – first prevocational stage	Provisional scope, or student scope, or with conditions that recognise the doctor can have direct patient contact but must have supervision and still has limitations in some areas	In this scope the doctor-in-training has limited ability to prescribe and order tests. The doctor-in-training cannot work unsupervised in an emergency department or at nights. The doctor-in-training is able to take patient's consent on non-interventional or minor procedures.	The medical school in conjunction with the Medical Council would assess whether the doctor is capable of clinical practice in hospital settings. The Medical Council would set the standards and accredit clinical placements. METU would coordinate the training. The doctor-in-training would be employed by METU.
Doctor-in-training – second prevocational stage	Provisional scope	Now the doctor-in-training can have greater involvement in service provision. The doctor-in-training can now do nights without direct supervision and can do informed consent for all procedures. The doctor-in-training can do nights if a senior is available.	The Medical Council would set the standards and accredit clinical placements. METU would coordinate the training. The doctor-in-training would be employed by METU.
Doctor	General scope of practice – fully registered	Now the doctor can work without supervision. At this stage the doctor may be moving into specialty training. If not, the doctor must take part in a continuing professional development (CPD) programme to gain Medical Council recertification.	
Doctor-in-training in a specialist training programme	General scope	At this stage the doctor is linked with a college or vocational training programme in a specialty area.	The programme is set by the college or vocational branch. METU would work with colleges and the Medical Council, as the doctor-in-training will exit with vocational registration and possibly fellowship. Medical Council involvement is required, as at the end of this point the doctor-in-training will get vocational registration. Employed by METU.
Specialist doctors	Vocational scope	Now the doctor works within the specialty area.	Maintaining professional competency.

Appendix 6: The Role of the National Director of Medical Education and Training (National Director)

The *National Director* would be responsible for the overall management and quality control of the implementation of the education and training programme, and for promoting the coordination of medical education and training across the continuum.

The main roles of the National Director would include:

- taking responsibility for the operational aspects of implementing the education and training programme and assessment system; that is:
 - overseeing the implementation of the education programme framework
 - coordinating mapping processes to identify training clinical placements that can be used by doctors-in-training to gain the competencies and skills
 - coordinating resources and promoting best practice and innovative ideas to minimise the duplication of resources, which is currently endemic in the sector
 - ensuring adequate evaluation of the system
 - maintaining an electronic storage database for doctor-in-training details, and e-learning and portfolios
 - consulting with key health service providers and key trainers to ensure they support the New Zealand Education Prevocational Framework
 - providing information for trainees, such as the UK Foundation Programme's *Rough Guide*
 - stimulating the development of vocational guidance, mentoring and guidance for doctors-in-training in their career choices, and providing avenues for remedial action if they are not progressing through training
 - ensuring there are sufficient quality clinical placements or training placements for doctors-in-training
 - ensuring coordination with the medical school and vocational training programmes and placements
- implementing the instructions of METNZ to ensure coordination across the continuum of medical education and training
- ensuring that national standards in medical education and training across the continuum are defined, met and maintained
- providing an advisory and mentor service to the regional and local educational supervisors
- strengthening links with undergraduate and postgraduate trainers, and ensuring through facilitation there is a smooth transition throughout the learning continuum from student education to vocational training
- supporting research and cross-fertilisation in areas of education, training and assessment.

The National Director would be required to forge strong links with all trainers and training institutions in the sector to ensure the strategies implemented can work at the grass roots. He\she would report to METNZ.

Appendix 7: The Role of Regional Directors of Education and Training (Regional Directors)

The *Regional Directors* will assist the National Director. The National Director is responsible for the overall management and quality control of the implementation of the national education and training framework and the coordination of medical education and training across the continuum. The role of the Regional Directors will include assisting the National Director by:

- taking responsibility for the operational aspects of implementing the national framework, the educational aspects and the assessment system in their region
- overseeing the implementation of the education and training programme in their region
- overseeing the implementation of an assessment system for prevocational training in their region
- monitoring the attendance and performance of each doctor-in-training at regular intervals, and initiating remedial support for any doctor in difficulty
- coordinating and linking the delivery of training in the regional and local areas and ensuring national initiatives are implemented regionally and locally
- ensuring coordination with medical school and vocational training programmes and placements
- ensuring training is delivered to those involved in training in the region – training the trainers
- acting as a coordinator for resource development and integration across the region.

Regional Directors will assist educational supervisors and clinical supervisors by:

- relating to and having a performance contract with local educational supervisors and clinical supervisors
- providing peer support for educational supervisors and clinical supervisors in their region.

Appendix 8: The Role of the Educational Supervisors

The key requirement of the role would be responsibility for the overall management and quality control of the educational programme in their training institution to ensure each doctor-in-training can access a comprehensive range of experiences that will enable them to gain the competencies necessary for full registration, and any other strategies in medical education and training promoted by METNZ.

The educational supervisor would be responsible for monitoring, supporting and assessing the doctor-in-training's educational programme and progress. This includes assessment, and/or the collection of assessment results. The main roles would be to:

- manage the quality control of the training at his/her institution
- work with the others in medical education and training to ensure the training programme meets the requirements of METU
- ensure each clinical placement meets the educational aims specified
- assist the coordination with medical school and vocational training programmes and placements
- ensure systems are in place to train and develop the skills of the clinical supervisors
- participate in the development of postgraduate medical education
- participate in the ongoing research and development of medical education and training
- work with other educational supervisors in the region and facilitate a coordinated approach
- contribute to the overall development of the medical and educational training
- attend development programmes for educational supervisors and maintain skills in medical education.

With respect to doctors-in-training, the main roles will be to:

- ensure that all doctors-in-training have access to clinical training, suitable induction, coordinated generic teaching and educational supervision
- provide educational support and advice to the doctors-in-training, especially in regard to:
 - assisting with the gathering and collation of high-quality data and evidence
 - providing summative feedback about competence and performance
 - providing additional tutorials to enhance the learning of doctors-in-training
 - providing advice on study leave, flexible study options and careers
- ensure all doctors-in-training have access to clinical supervision and assessment
- monitor the attendance and performance of each doctor-in-training at regular intervals and initiate remedial support for any doctor in difficulty
- track the progress of doctors-in-training through their assessments towards achieving the relevant waypoints
- identify early those doctors-in-training who need to be recommended for a remediation programme
- contribute to the delivery of small-group teaching and learning within their region (or to the development and delivery of modules of learning)
- interact and collaborate with other educational directors to share best practice and implement improvements

- assist the regional office to maintain databases of doctors-in-training within the programme, including details of their placements, supervisor(s), assessment results, attendance at generic teaching and study leave.

The educational supervisors would continue to be employed by a DHB or training institution and would be accountable to the National and Regional Directors for the work they perform in relation to the education and training of doctors-in-training. This would be done via a contract with key performance indicators.

Appendix 9: The Role of the Clinical Supervisors

Clinical supervisors will continue their current role in the day-to-day supervision of clinical and professional practice. They will need to support the assessment process required of each doctor-in-training for whom they are responsible. This will require them to:

- ensure doctors-in-training in their areas have the appropriate range and mix of clinical experiences and exposures to meet the competencies and levels
- arrange a work programme that enables doctors-in-training to attend fixed educational sessions and have a minimum time each week to complete assessments and undertake self-reflection
- be responsible for monitoring, supporting and assessing the doctor-in-training's clinical and professional work
- be responsible for completing all assessments required (or ensure they are done), and give full feedback to the doctors-in-training at regular intervals (at present three times per clinical placement – beginning, middle and end)
- meet regularly with the educational supervisor in their area to encourage sharing of expertise and knowledge, and to increase consistency across specialty areas.

Appendix 10: Mapping of Main Roles in the Sector, and a Possible Future Role for METNZ

	Role of medical school	Role of Medical Council		Role of vocational branches and professional colleges	Role of METNZ / METU
		For the doctors-in-training	In the system		
Student	Delivers student education and training and is responsible for doctors-in-training when on placements and in the trainee intern year		Sets standards for outcomes expected of students, with AMC accrediting medical schools that meet registration standards		Could include students in any database and IT tracking systems, and could assist medical schools to locate clinical placements for students and trainee interns.
Prevocational doctor-in-training years		Requires doctor-in-training to work under supervision. Sets requirements for what the doctor-in-training can do safely (eg, whether can do nights). Registers doctor-in-training in a provisional scope of practice. Accepts if the doctor-in-training is in formal training; this will assure competency (ie, no other CPD required).	Sets standards for clinical placements in DHBs so that the doctor-in-training receives the appropriate education, training and experience for the doctor-in-training to be fully generally registered. Accredits hospitals as being able to provide requirements for training institutions. Accredits clinical placements as suitable for doctors-in-training.	SMOs (who are usually members of the colleges) will act as clinical supervisors for doctors-in-training.	Would work with the Medical Council to ensure standards for clinical placements are appropriate. Would employ doctors-in-training, and via IT tracking systems would monitor clinical placements completed, portfolios and progress of doctor-in-training.
Doctor who is registered in a general scope		Registers doctor-in-training in a general scope of practice. Requires doctors to be in a collegial relationship and to take part in CPD.			
Doctor-in-training in provisional vocational training		Accepts if the doctor-in-training is in a vocational training programme. This will assure competency (ie, no other CPD required).	With AMC, accredits the college and vocational branch programmes.	College seniors (SMOs) tutor training registrars in training posts approved by the college.	Would work with the Colleges and vocational branches to ensure standards for specialist training posts are appropriate. Would employ doctors-in-training and, via IT tracking systems, would monitor training posts.
Doctor who is registered in a vocational scope/specialist		Registers doctors in a vocational scope of practice. Doctors are required to do CPD via a Medical Council-accredited recertification programme, usually delivered by college and vocational branch.	Accredits CPD programmes provided by colleges and vocational branches.	Organises CPD programmes.	

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