Postgraduate medical education in New Zealand: at the crossroads

Don Simmers

Earlier this month a memorandum of understanding was signed between the Medical Council (MCNZ), Health Workforce New Zealand (HWNZ), and the College of General Practitioners (RNZCGP).

The three parties have agreed to “implement a revised vocational training programme for general practitioners from 2012”. The new programme aims to raise the popularity of the vocation of general practice among medical students and junior doctors and involves GP registrars embarking on a 3-year course which combines training in both community and hospital settings. Sitting alongside this development is the announcement that it will also be “scoping the feasibility of requiring doctors to have vocational registration in order to work in general practice in roles other than as a trainee”—resulting in a quantum leap of numbers undergoing GP registrar training.

RNZCGP’s Fellowship of the Division of Rural Hospital Medicine, operational since December 2008, has many similarities with this proposal. It is a combination of sitting relevant papers available at the two medical schools with experiential registrar level learning in general practice and at various provincial hospitals. It concludes with a comprehensive assessment. The recently signed memorandum starts with reviewing this well thought-out programme and it is to be hoped, if not assumed, that the enormous effort that has already gone into establishing the Rural Hospital Medicine programme will be recognised and built on.

The new 3-year programme, if implemented and funded appropriately, could result in significant improvements to the delivery of New Zealand’s health care, while compulsory vocational registration will solve a number current thorny problems around lack of vocational registration in some parts of the health system. But the change process and initiation of the programme needs to be handled carefully if some of its drawbacks are to be minimised.

In explaining the effects of the new programme in his interview with Radio New Zealand, Professor Des Gorman described how GPs could admit and look after their patients when they need acute hospital treatment. While this may be a possibility in some provincial hospital settings—and already occurs in rural facilities—it would seem a most unlikely scenario in the major centres. The costs alone would be prohibitive no matter how funding is structured, but there are also issues of unplanned disruptions to GPs’ surgeries and gradual erosion of skills and knowledge used only occasionally.

Acute medical admissions within a GP’s practice population are relatively uncommon. A far better approach is to include the inpatient’s GP in any decision-making, particularly if the clinical situation is complex. There is, of course, no good reason why this should not be a routine occurrence now.
A much more obvious improvement will be the ability of GPs to expand the depth, breadth, and quality of the services they already provide in community-based settings. The increased knowledge, experience, and confidence that will come from the registrar experience will result in fewer hospital specialist referrals, fewer acute admissions and better handling of chronic disease. However, there will need to be a number of structural changes made to fully realise these advances.

There will need to be better networking between specialists and GPs, and GPs will need an unfettered access to imaging. This will have to be matched by rounds with radiologists and more than the current cursory contacts will have to be arranged with pathologists, pharmacists and other allied health professionals. All of this takes time—and money.

Expansion of GP services into the vacuum created by the decades-old demise of the general physician is an obvious attraction of this new scheme. Also, there are clear advantages in GPs providing more comprehensive ED services, mental health care, and elderly health care. GP registrars need to be encouraged to pursue areas of special interest during their training and have this recognised through gaining recognisable postgraduate qualifications. They could continue to develop and use this expertise through working in specialist-led clinics, or provide specialist services in outreach clinics, or provide services for their peers in their own integrated family health centres.

GP obstetricians need to reappear in provincial and rural areas and be comfortable with a basic range of interventions as well as cope with any obstetric emergency. But how far should this “generalists can do anything” thinking go? Should there be a return of the GP anaesthetist, and should GPs get into laparoscopies or perform caesarean sections? In some provincial areas of New Zealand, the answer may well be yes, given the perennial difficulties of retaining a range of specialist services in these locations.

As mentioned, the process of developing this programme will have to be well managed. Providing the educational environment in which this greatly increased population of GP registrars will work in will be a significant challenge. Consultation rooms plus the availability of quality teachers and supervisors in the general practice setting loom as the biggest hurdles. General practice cannot be expected to meet these challenges on its own—government support and funding will be essential. The retention of university-led education programmes, as developed for Rural Hospital Medicine training, where registrars have time away from service-dominated clinical work, needs to be considered.

There is already a shortage of GPs and of those who are left many are near retirement. In urban areas, at least, only a few will have the necessary skills to consult, let alone teach at the appropriate level required. There will need to be a significant investment in new or expanded facilities. There will need to be significant investment in teaching the teachers and provision of ongoing support, including an appropriate income.

Added to this are any number of issues including grandfathering (proper recognition of GPs already qualified under old regulations), registrars who only wish to work...
part-time, the fate of those who fail, and not least, the relationship between RNZCGP and the other specialist colleges.

If all of this is not a big enough conundrum, then added to this is the anticipated increase in medical school graduates looking for work in New Zealand from 300 per annum in 2009\(^8\) to possibly 500 in about 5 years’ time. At current employment levels for PGY1s within the hospital system, an extra 200 positions will need to be found, and by default these will have to be in community settings.

The deliberations of the working group responsible for the review are awaited with keen anticipation.

Competing interests: None known.

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