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# AMPA's comments on MCNZ's 'Prevocational training discussion document'

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# I. Summary

AMPA's main points are summarised here (and in bold in the body of this document), and are followed by a more detailed response with answers to Council's questions.

## A. General comments

- AMPA strongly supports Council's proposed changes.
- Advantages include (in addition to those Council has mentioned already):
  1. A headstart to A&M / GP training.
  2. More doctors choosing GP / A&M.
  3. Better relationship between hospital doctors and A&M doctors / GPs.
  4. More community-based patient care, and so perhaps better, cheaper and more convenient care.
  5. More work for GPs / A&Ms.
  6. More varied work for GPs / A&Ms.
  7. Better training.
- Introduce changes slowly, and use pilot schemes if practicable, with assessment and review.
- Avoid others' problems and mistakes, e.g. those of the UK's 'Modernising Medical Careers'.
- Change the term 'prevocational training' to 'house surgeon training'.
- Reword the purpose statement as follows

  *"House surgeon training will give doctors a broad knowledge of hospital and community practice through compulsory hospital and community runs and a standardised teaching programme and assessment, on successful completion of which doctors are eligible for General Registration."*
- Merge the 'objectives' (which seem to be features) and 'key features' lists into one features list.
- Medical schools have 'no time' for clinical topics such as Accident and Medical practice. Give Colleges more say in medical school teaching.
- Consider whether the proposed changes will affect compatibility and comparability with other countries' medical training.
- Look at whether New Zealand could reduce the length of its medical training (from eight years to as few as four, as in Canada), save up to four years of tertiary education expense, add up to four years to average career length and still produce top quality doctors.

## B. House surgeon training

- AMPA agrees with changes that will restore traditional apprenticeship learning in a consultant / registrar / house surgeon team, and minimise use of hospital locums.
- AMPA strongly supports a national house surgeon curriculum and training programme, to include mandatory runs (per Council's options) and a module of learning material, learning objectives and assessment for each mandatory run.
- It is vital that each run's learning module be relevant, clinical, interesting, focussed on learning, be a pleasant experience and not unduly onerous or a barrier.

## C. House surgeon runs

- AMPA prefers three month runs to give doctors more runs and broader experience.
- A&M practice is an under-recognised part of medical care in New Zealand, accounting for over one million consultations per annum. An AMPA survey shows interest from A&M Clinics in providing about 100 house surgeon training runs per annum. AMPA estimates total Clinic capacity at around 180-240 runs per annum.
- AMPA suggests a pilot A&M house surgeon scheme, in accredited A&M facilities with a FAMPA on-site with the house surgeon at all times.

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- Require, as a minimum, that a doctor who locums in General Practice has at least completed a GP 'run', and that an A&M doctor has at least completed a GP, Emergency Medicine or A&M run, and in all cases passed the attached training module.
- Rural Hospital Medicine is very broad and in AMPA's view would be a good choice for a mandatory run, perhaps as an alternative to Emergency Medicine. RHM often includes Emergency Department work, as well as ward and outpatient work
- Ideally, house surgeons would do runs in GP, Emergency Medicine, A&M, or Rural Hospital Medicine in their second year only.

## D. Run selection:

- Ideally all house surgeons would do a run in General Practice.
- Rural Hospital Medicine is very broad and in AMPA's view would be a good choice for a mandatory run, perhaps as an alternative to Emergency Medicine.
- Compulsory runs in General Practice, A&M, Rural Hospital Medicine and Emergency Medicine are the best fit with Council's aim of experience and training in general, broad, acute and community runs.
- Other community runs, such as Community Mental Health and Drug and Addiction, will not give a suitably broad experience.
- Give house surgeons a choice for one of the mandatory runs, to include psychiatry and others that meet Council's objectives – including perhaps Geriatrics.
- Council has suggested four options. AMPA suggests a fifth as follows:
    1. General registration after two years.
    2. Three month runs in:
        a) General Medicine
        b) General Surgery
        c) General Practice or A&M Practice
        d) Emergency Medicine or Rural Hospital Medicine
        e) Psychiatry, Geriatrics or [other high-ranking branches as decided by Council].
        f,g,h) Three optional runs.
    3. No less that eleven weeks worked in mandatory runs a) b) and c).

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# II. Introduction and general comments

In general, **AMPA strongly supports Council's proposed changes** to House Surgeon training.
We think 'Prevocational' is an unclear term – it could mean the entire training from medical school until vocational training begins, or even until vocational training is complete, but the document is talking only about the house surgeon years.

**AMPA suggests changing 'prevocational training' to 'house surgeon training'**, as 'house surgeon' is immediately understood and is the most widely used term in New Zealand for the PGY1 and PGY2 years.

# III. Key questions

(see P8 of Council's document)

## A. Important drivers or issues that were omitted or understated

### 1. AMPA's comments on issues Council identified

#### a) Lack of 'vertical integration'…

We take this to mean the issue that different groups control different parts of medical training – Universities control the medical school years, Colleges the vocational training, and other parties the training that occurs in the house surgeon years, and that better communication between these groups, or overall control by one group might give better training.

If this is what is meant, AMPA strongly agrees, and suggests **Colleges have more say in medical school teaching**. One approach would be to ask each College what every doctor must know of their Branch by the end of PGY2, and rework the medical school and house surgeon training to make sure it is taught.

AMPA would like to teach some Accident and Medical Practice in medical schools. Currently there is no Accident and Medical teaching, though there are over one million Accident and Medical consultations per annum in New Zealand.

AMPA's understanding is that medical schools see themselves as under constant pressure to omit or include topics that medical school department heads think are important, and have 'no time' for clinical subjects such as Accident and Medical practice.

AMPA's view is that ten hours (say) of Accident and Medical practice teaching is much more worthwhile than the Krebs cycle, dissecting the cranial nerves of the dogfish, or re-proving Starling's Law on anaesthetised dogs, to name just a few pre-clinical topics. We think medical students would agree.

#### b) Balancing increasing service demand…

We understand this point to mean firstly that hospitals want junior doctors to work and may be neglecting teaching. Secondly, junior doctors are doing hospital locums instead of runs, to earn more, and not working in a traditional 'team' (consultant / registrar / house surgeon). Even doctors who do 'runs' (as opposed to locums) now hand over to other doctors and do not take ongoing responsibility for patients, to the degree they once did. The valuable 'apprenticeship' teaching system is now not working well.

**AMPA agrees with changes that will restore the traditional 'team' and apprenticeship learning, and minimise hospital locums**. AMPA members report that some of their most valuable teaching happened via 'apprenticeship'. This style of teaching can not be enforced or regulated, but the desire to teach and to learn seems to be inherent. At best, hospitals can try to create an environment that fosters apprenticeship learning, such as existed and began to disappear perhaps thirty years ago.

#### c) Gap in training

There is no standardised formal training for house surgeons.

AMPA strongly supports a national curriculum and standardised training programme for house surgeons, to include mandatory runs (per Council's options) and a module of learning material, learning objectives and assessment for each mandatory run.

The mandatory runs and modules would aim to teach material every doctor should know, regardless of eventual specialty.

AMPA can readily make an Accident and Medical module suitable for house surgeons doing an Accident and Medical run.

Council could also require a module for each optional run.

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### d) 'Core competencies' – training too specialised.

Council's document makes the point that New Zealand needs more doctors who can a) treat a broad range of conditions, including in rural areas b) treat age-related conditions and c) treat a broad range of illness and accidents.

This could mean:

1) Training 'generalists' who are trained to treat a broad range of conditions.

2) Giving all doctors some core 'generalist' training.

3) Encouraging specialists to keep a broad range of skills in their specialty, and less sub-specialisation.

4) Setting up a system where 'generalists', with suitable additional training, may work in a limited way in other branches.

AMPA strongly agrees. AMPA trains 'generalists' who treat a broad range of acute illness and accidents.

A&M clinics can potentially accept up 60 house surgeons per run, or 180 house surgeons per annum, based on four month runs (240 house surgeons if three month runs). In practice, it's unlikely A&M would take that many.

**AMPA suggests a pilot scheme, in Standards New Zealand accredited A&M facilities with a FAMPA on-site at all times with the house surgeon, building up numbers to capacity (perhaps 100 per annum) according to the pilot results**.

### e) Too much hospital training – not enough community training and disease prevention

AMPA strongly agrees, and in passing, notes that many common diseases such as hypertension and diabetes and their sequelae, an enormous burden to the health system, are preventable consequences of Western lifestyle, in particular, diet.

### f) Second year house surgeon locums and safety concerns

As above, AMPA supports measures to reduce second year house surgeon locums and restore the consultant / registrar / house surgeon team.

As mentioned on page 26, Council is considering whether second year house surgeons should be permitted to locum in General Practice. The same concerns apply to second year house surgeon A&M locums, and indeed to any A&M locum who has not had A&M or ED experience.

Council notes (p26) that in hospitals, there is a 'team environment', in which second year house surgeons have more support and supervision than in General Practice. AMPA believes that a 'team environment' exists in A&M Clinics too, where there are usually other doctors, including FAMPAs on-site, nurses triage patients before the doctor sees them, and treat them after, and a medical director who reviews patient notes. Often, another doctor will handle follow-up visits.

AMPA believes **it would be reasonable as a minimum that a doctor who locums in General Practice has at least completed a GP 'run', and that an A&M doctor has at least completed a GP, Emergency Medicine or A&M run, and passed the attached training module** (as proposed above).

### g) No measure of value for money in house surgeon training expense.

Council suggests 'key performance indicators'. AMPA supports some assessment but would like to see it kept simple e.g. not applied to all cases, where a sample survey or analysis would do, collecting the minimum information necessary, and using plain English.

Doctors are sick of paperwork and latest management theory and even terms such as KPI may alienate some.

## 2. Other issues AMPA has identified

### a) Length of medical training

Ideally, how long should medical training be? Shorter training should be cheaper and could mean a correspondingly longer career. What is the shortest training time consistent with safe patient care?

The document mentions that Canadian medical school training comprises two years of 'basic subjects' and two of 'clerkships where students spend supervised time in clinical runs', after which doctors can move directly into vocational training.

The New Zealand system is four years longer – three pre-clinical years, two clinical, a trainee intern year and two house surgeon years (uncommonly, one).

The document states '..it is important to note that MOST provinces require that applicants to medical school first complete a university degree.'

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What has been the experience of provinces that do NOT require a prior University degree? What is the importance of the prior university degree? Are there problems with doctors who complete medical school at age 22 and enter vocational training after 'only' four years? Is 'looking too young' or 'lacking life experience' or 'having too narrow an outlook' a real problem or an old theory that has become an entrenched belief?

Given that the Canadians' pre-entry University degree could contribute nothing medical to medical training – why does it take New Zealand eight years to achieve what Canada does in four?

If there are genuine problems with doctors qualifying 'too young' - is the University degree worth the expense (to student and country) or would the intending medical student be better off working? Would a minimum entry age of, say, twenty be better, leaving the student flexibility to work or study? Or encouraging (rather than as now discouraging) students to take a break after the pre-clinical years?

**Could New Zealand halve the length of its medical training, save four years of tertiary education expense, add four years to average career length and still produce top quality doctors?**

AMPA suggests, if training is to be shortened, that it be done gradually, for example, by reducing basic science years from three to two, then later by dropping the trainee intern year – moving its teaching into the house surgeon and clinical medical school years.

### b) Greater understanding and use of community resources

The AMPA Committee's collective experience is that hospital doctors who have worked in community practice have a greater understanding and make more use of community resources when devising care plans. We believe this gives better cheaper care. The document makes this point ('Training too hospital focussed') but we believe it deserve more emphasis.

### c) Relationship between community practice, hospital practice and medical schools

Our experience is that hospital doctors (and medical school lecturers) who have worked in community practice have more respect for it and its practitioners. Many doctors enter medical school expecting to become the doctor who they have seen the most – a general practitioner. Many lose this ambition during the medical school and house surgeon years.

We hope compulsory community practice runs will in time **improve the standing of community practice**, remove a barrier to entry, and improve relations between hospital and community practice.

### d) Low awareness of A&M

Most hospital doctors, while knowing of and using A&M Clinics do not realise that A&M is a Branch.

**In AMPA's view A&M practice is an under-recognised part of medical care in New Zealand, accounting for over one million consultations per annum**. We expect compulsory community runs will help. AMPA doesn't see this as an important driver, other than to AMPA, given the scale of the changes Council is proposing, but we mention it in passing.

### e) Use only second year house surgeons for GP, A&M, ED and RHM runs

Council raises the question of whether it is safe for second year house surgeons to work (as locums) in General Practice. AMPA agrees, and would add A&M Emergency Medicine and Rural Hospital Medicine to the list.

A related issue which Council's document does not raise is whether first year house surgeons should do runs in those four Branches. The house surgeon may be the only doctor a patient sees in some cases.

In AMPA's view, a second year house surgeon is safer and also, from the Clinic's perspective, more valuable. This could mean Clinics are prepared to pay more for second year house surgeons, potentially reducing the cost of house surgeon training.

**AMPA suggests house surgeons do runs in GP, EM, A&M, or RHM in their second year only, as much as practicable.**

### f) Compatibility and comparability with other countries' medical training

**Will other countries accept doctors from New Zealand, as they do now, following the proposed changes?** We are not sure if Council (or the Government) sees this as a problem, though many doctors would.

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### g) Moving too fast

AMPA suggests **changes be brought in gradually and in some cases with a preparatory pilot scheme**. This should help to reduce the impact of unforeseen problems.

### h) Check for willingness

AMPA is enthusiastic about the proposal and our discussions with the RNZCGP indicate they support it too. How do other affected parties feel about it? Are junior doctors generally keen to have a community run? Do hospital consultants support it? Do hospital administrators and other employers?

It could be that some house surgeons do not see the point of a community run, when they plan to be hospital doctors. Those entering a run reluctantly are likely to get less out of it and have a poor experience. If this attitude is widespread, it is another argument for a pilot scheme.

Base on feedback from A&M trainees, and the results of an Health Workforce NZ-commissioned independent review of A&M training, AMPA believes A&M runs will be popular with house surgeons, and they will leave the run with valuable skills and knowledge and an appreciation of community based practice, and tell their colleagues.

A successful pilot scheme should be excellent advertising for a new system, as well as giving an opportunity to find problems and get the systems right.

### i) Learn from others' mistakes

The UK's 'Modernising Medical Careers' had problems which Professor John Tooke's review described as 'deeply damaging' for British medicine.

Problems included:

- Dissatisfaction with the national curriculum and 'learning portfolio'.
- Use of management consultants to try (unsuccessfully) to decide on important clinical matters such as systems for assessing skills. **We recommend asking Colleges to drive clinical training and assessment**.
- A centralised recruitment system, soon abandoned, that left 14,000 junior doctors with no jobs one year. **We recommend the existing recruitment system be left undisturbed for now.**
- Not enough time to decide on a specialty – doctors were expected to decide half way through the second house surgeon year. **We recommend that doctors retain the flexibility to work additional house surgeon years** (which will help hospitals) and apply for specialties when they are ready. Three month run length, rather than four, will also give more optional runs for house surgeons to assess career options.

## B. Do you agree with the objectives and principles? Would you add or delete any?

### 1. House surgeon training purpose statement

The purpose statement could be simplified or re-composed. It seems to have four distinct ideas.

**1) Purpose**

To prepare doctors to enter a vocational training programme.

**2) Content**

The MCNZ will prepare a curriculum.

**3) Assessment**

House surgeons must pass an assessment.

**4) Qualification on completing HS year(s)**

General registration

Some important ideas are missing from the statement:

**1) Mandatory community run**

Per three of the four options, and in line with Council's preferences.

**2) Modular learning**

Each mandatory run will have a learning module attached.

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**3) National programme**

All house surgeons doing a run will do the same module for that run.

**4) Stress on 'broad' knowledge.**

A simple 'purpose statement' covering the main points could read as follows:

> ***House surgeon training will give doctors a broad knowledge of hospital and community practice through compulsory hospital and community runs and a nationally-consistent teaching programme and assessment, on successful completion of which, doctors are eligible for General Registration.***

## 2. Objectives

(see p5)

In general, this seems to be a list of features or components Council intends for house surgeon training, rather than 'objectives'. Objective and purpose (above) are synonyms. Since it comprises mainly features, the 'Objectives' list could be condensed and incorporated into the 'Key Features' list (see 'Objectives and key features list' below).

AMPA's comments on the 'objectives' (rephrased in simple language) are as follows:

1) Will build on medical school training

Omit – self-evident.

2) House surgeons and their trainers will understand the purpose of the training programme

Omit – self-evident

3) Trainers will understand what they're supposed to do

Omit – self-evident. Does Council plan guidelines for trainers?

4) Training will be integrated

Omit – meaning unclear – jargon

5) Training and service are equally important

Omit – it's true but trite to say both are important, and, we think, unhelpful to debate which is more important.

6) House surgeons will get good supervision from their seniors

Agree – reword - on each run, house surgeons will have and work alongside a senior doctor supervisor.

7) Training will be mainly experience-based

Council's document states it will be a mix of apprenticeship and modular learning.

Change to "training will comprise a mix of 'apprenticeship' learning, via a traditional consultant / registrar / house surgeon team, and learning modules specific to each mandatory run."

8) Doctors will train in hospitals and in the community

Agree – reword "Training will include at least one mandatory community run" – the hospital runs are a given – the important change is more community runs.

9) Training will be broad-based and prepare doctors for vocational training in any branch.

Agree.

10) House surgeon training will be based on a national curriculum, which will cover clinical care, communication and professionalism.

10a) (new) Each mandatory run will have an attached module, comprising learning objectives derived from the curriculum, and an assessment which house surgeons must pass as a condition of general registration. The assessment will include an opinion from the house surgeon's run supervisor.

11) The curriculum will stress illness and age-related conditions.

Agree – suggest using simple wording as above.

12) Learning objectives and assessment thereof for each run – omit – covered in 10a) above.

13) Senior doctors should supervise and train house surgeons.

Reword - The training programme will seek to support senior doctors in training and supervision and foster the traditional consultant / registrar / house surgeon team and learning environment.

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[Specifically, this could include some paid time for teaching and assessment]

## 3. Principles

Safety paramount – good medical practice – good value

These are unarguable, thought perhaps self evident.

'Adult Learning Theory'

We would be wary of making of making an academic theory of the day part of a long-term plan.

## 4. Key features

For simplicity, we suggest condensing the 'objectives' list above (in our view they're not objectives) and merging with the 'key features', and have done this below (see 'Combined Objectives and Key Features')

AMPA's comments on the 'key features' follow:

### a) Extend run length

We don't understand why a three month run is "in reality …. less than ten weeks" (p 29). Three months is thirteen weeks. If a house surgeon takes four weeks holiday and sickness per annum, each three month run is twelve weeks on average.

AMPA would be happy with the proposed four month runs but wonders if retaining **three month runs would be a better option. It gives doctors more choice, more runs and thus a broader experience**. It allows extra mandatory runs without unduly narrowing the selection of optional (and 'service') runs. Council could require that doctors spend a minimum of 11 (or even 12) weeks on each mandatory run (with case-by-case assessments in the event of long illness).

### b) Additional mandatory runs in Community Care, Emergency Medicine and Psychiatry.

In AMPA's view, and as stated elsewhere in the discussion document, **important goals include more general, broad, acute and community runs**.

We think that **compulsory runs in A&M, General Practice, Rural Hospital Medicine and Emergency Medicine are the best fit with these aims**.

AMPA agrees with Council that **ideally all house surgeons would do a run in General Practice**, given that General Practice accounts for more doctors and more consultations than all other branches combined.

Given that the curriculum stresses aged care, we think there is as much case for a compulsory geriatrics [or other runs] as for psychiatry, but that the case for either is weaker than for the three runs above.

Likewise, we think other community runs, such as Community Mental Health, and Alcohol and Drug Services, will not give a suitably broad experience for house surgeon training purposes, and should be low priority for mandatory run status.

We see the following benefits of a mandatory run in A&M / General Practice:

#### (1) Headstart to A&M / GP training.

Closely supervised training and assessment can begin in the first house surgeon year.

#### (2) More doctors choosing GP / A&M

Compulsory runs mean more doctors get a taste of GP / A&M which might lead to more doctors choosing a community-based career.

#### (3) Better relationship between hospital doctors and A&M doctors / GPs.

Doctors who have worked in GP / A&M seem to better understand, support, respect, communicate and collaborate with primary care doctors, in AMPA's experience.

#### (4) Better cheaper and more convenient patient care

If specialists have worked in GP / A&M, they might better understand and use non-hospital resources, which are cheaper for the country and more convenient for patients, in their patient care plans.

#### (5) More work for GPs / A&Ms

#### (6) More varied work for GPs / A&Ms

Doctors may be more willing to enter and remain in GP / A&M if the work is more varied and fulfilling.

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### (7) Better training

Currently the house surgeon training is sporadic, unplanned and largely optional. Every doctor is taught different things - it can depend on what the grand round topics and Department teaching are at the time.

A formal nationally-consistent programme (that need not be high pressure) should give doctors more consistent and more useful learning - i.e. proper training.

### c) New curriculum (derived from Australian Medical Council)

AMPA supports this in principle.

As presented in the discussion document, the curriculum is a mix of non-clinical items that apply to all branches (e.g the Professionalism section) and coverage of some clinical topics e.g. anticoagulation.

We suggest Council prepare the non-clinical items, and ask the College for each mandatory run to prepare items for the clinical curriculum, and a learning module, to include learning objectives, assessment, and an outline of teaching methods.

The UK experience of Modernising Medical Careers was that most house surgeons did not think the national curriculum and 'learning portfolio' was an improvement on the old system. Accordingly, it seems **the quality of the curriculum and learning module is vital** and, based on the UK experience, a potential problem.

We think it is vital that the educational material of the learning module be relevant, clinical, interesting, focussed on learning, be a pleasant experience and not a barrier.

We recommend that the **house surgeons' experience and opinions of the material be assessed**. Health Workforce New Zealand commissioned an independent survey of AMPA's A&M Care Course (AMCC), and this sort of survey, we believe, would help determine if the curriculum and learning modules were working.

Based on the AMCC survey, AMPA is confident of providing a house surgeon module that meets the above criteria. AMPA's A&M module would be derived from the A&M Care Course and include the following:

### (1) Learning objectives

Distilled from the A&M Training Programme learning objectives

### (2) Teaching material

To include:

1) Journal articles and other distance learning material distilled from the A&M Care Course.
2) Weekend course - ACLS
3) Weekend course - communication; practical skills.
4) Seminars – at the start of the run, and after one week, one month and two months.
5) Specialist clinics – mandatory attendance at a Clinic's fracture and plastics clinics.

### (3) Supervision

House surgeons would work 'shoulder to shoulder' with a FAMPA supervisor, who provides apprenticeship learning through gradual delegation, starting with, for example, laboratory results, plaster checks and change of dressings, and moving on gradually and in closely supervised fashion to wound management, suturing, and fracture management.

Often an A&M registrar will also be on-site. The house surgeon will learn in the traditional team environment through observation and immersion in an A&M environment.

### (4) Assessment

To include

1) Written examinations testing curriculum and learning objectives
2) Viva testing basic practical skills
3) Audit – e.g .patient notes audit, case management audit, referrals audit, xray diagnosis audit.

Most of these resources are already in place.

## 5. Combined 'key features' and 'objectives' list

AMPA suggests a 'key features' list (combining the misnamed 'objectives' list) as follows:

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#### a) National curriculum

House surgeon training will be based on a national curriculum, which will cover clinical care, communication and professionalism.

#### b) Training through apprenticeship and learning modules.

Training in each mandatory run will comprise traditional 'apprenticeship' learning, via a traditional consultant / registrar / house surgeon team, and standard learning modules specific to the run.

#### c) Learning modules for mandatory runs

Each mandatory run will have an attached module, comprising learning objectives derived from the curriculum, and an assessment which house surgeons must pass as a condition of general registration. The assessment will include a clinical performance assessment from the house surgeon's run supervisor.

#### d) Supervision

On each mandatory run, house surgeons will be closely supervised and work alongside a senior doctor supervisor.

The training programme will seek to support senior doctors in training and supervision and foster the traditional consultant / registrar / house surgeon team and learning environment, for example, with paid non-clinical teaching time.

#### e) Community runs

Training will include at least one mandatory community run.

#### f) Broad base

The training will include three mandatory runs that are broad-based and prepare doctors for vocational training in any branch.

#### g) Other priority areas

House surgeons will choose one mandatory run from a Branch covering priority health needs: age-related conditions, prevention, long term management or mental illness.

## C. Should there be mandatory runs? Which ones?

(See AMPA's recommended alternative option below)

- General Medicine
- General Surgery
- One of General Practice / A&M Practice
- One of Rural Hospital Medicine / Emergency Medicine
- One from a list of priority branches decided by Council. Psychiatry and Geriatrics, for example, seem to meet Council's objectives.

## D. What is the appropriate length of internship?

Two years. Few doctors choose to leave after one year and those that do cause concern.

## E. What are the consequences of each option?

### 1. General comments

#### a) Run length

Four month runs in AMPA's view have some important disadvantages compared to three months.

##### (1) Fewer optional runs

##### (2) Less breadth of experience

This is important for A&M (see example below) and also for intending hospital specialists.

##### (3) Choosing a specialty

A major criticism of Britain's 'Modernising Medical Careers' was that doctors were asked to choose a specialty after only one and a half house surgeon years and often without having done a run in the specialty. Three month runs would give doctors more opportunity to try different specialities.

##### (4) Lost opportunity to take career-enhancing runs

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For example, in option two, a doctor planning to enter Accident and Medical Practice might do General Medicine, General Surgery, A&M and Emergency Medicine as mandatory runs.

With four month runs, there would only be time for two optional runs. With three month runs, there would be four optional runs.

For example, an intending A&M Practitioner could do optional runs in orthopaedics, plastic surgery, general practice and paediatrics, instead of having to choose two.

In AMPA's view, those four runs of three months give a much broader and more useful experience for A&M purposes than two of four months, and should produce a better A&M Practitioner.

**(5) Fewer doctors able to do some runs, where there is a shortage of runs.**

For example, if A&M can accommodate 120 house surgeons per annum doing four month runs, it would accommodate 160 if runs were three months. If, as Council suggests, there is a shortage of Community runs, **reducing run length to three months will increase run numbers by a third**.

The discussion document suggests three month runs would be ten weeks, maybe less, but the starting point is thirteen weeks, and Council could consider requiring a minimum of, say, eleven weeks per mandatory run.

## 2. Option one

Four month runs in a) Medicine in General b) Surgery in General c) Community Care (GP, A&M, drug and addiction) or Emergency Medicine

### a) Questions and comments

1) What does 'Medicine in General' and 'Surgery in General' mean? Is it General Medicine / Surgery only, or any medical or surgical run, or 'broad' medical and surgical runs only? AMPA favours General Medicine and General Surgery.

2) AMPA believes that Community runs other than A&M and GP are not broad enough to give good experience in community medicine.

3) **Rural Hospital Medicine** is very broad and in AMPA's view **would be a good choice for a mandatory run**, perhaps as an alternative to Emergency Medicine. RHM often includes Emergency Department work, as well as ward and outpatient work.

### b) Consequences

Doctors could avoid community runs altogether (by doing Emergency Medicine).

Doctors could have a Community Medicine experience that is too narrow to meet Council's goals. A doctor doing an Addiction run will not get a good understanding of General Practice.

## 3. Option Two

Four month runs in a) Medicine in General b) Surgery in General c) Community care (GP, A&M, drug and addiction) d) Emergency Medicine. General registration after 16 months.

### a) Consequences

Less choice for house surgeons – only two optional runs – though could be mitigated by reducing run length – see comments above.

Doctors could have a Community Medicine experience that is too narrow to meet Council's goals. A doctor doing an Addiction run will not get a good understanding of General Practice.

Emergency medicine given more importance that General Practice – all doctors must do an EM run but GP is optional.

## 4. Option 3

Four month runs in a) Medicine in General b) Surgery in General. Limited general registration after twelve months.

### a) Questions and comments

The discussion document states a doctor in training can gain 'limited general registration', without doing general practice or emergency medicine, where the 'limitation'; is an inability to practise in emergency medicine or general practice.

The doctor must do both those runs in the second house surgeon year in order to a) get full general registration and b) get the right to work in Emergency Medicine / General Practice and c) 'complete the programme'. It isn't clear what 'completing the programme' means or what the consequences of not completing the programme are.

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The option seems to envisage doctors doing Emergency Medicine and General Practice in the first house surgeon year – *"If General Practice and Emergency Medicine were not satisfactorily completed in [the first house surgeon year]…"* To the best of AMPA's knowledge, hospitals strenuously avoid employing first year house surgeons, for patient safety reasons.

Does this option envisage a purely supernumerary / training role for first year house surgeons doing Emergency Medicine? In AMPA's view, the same concerns and considerations exist for first year house surgeons doing A&M, Rural Hospital Medicine and General Practice.

Can a doctor who plans to become a hospital specialist choose to not do General Practice (in particular) and Emergency Medicine, and live with the 'stigma' of limited general registration? If so, it could result in many doctors ignoring Council's objectives. They could do what they do now - choose only runs that are relevant to their intended specialty and get no community medicine knowledge or perspective.

What happens if a doctor does Emergency Medicine or General Practice but not both? How many types of limited practice are envisaged – e.g 'can't do GP or Emergency Medicine', 'can't do Emergency Medicine but can do General Practice' 'can't do General Practice but can do Emergency Medicine'?

#### b) Consequences

Many doctors will not gain any experience of community medicine (if it is in fact optional). Similar to the status quo. Seems to defeat Council's objectives.

A&M practitioners can enter A&M training without having done any General Practice or Emergency Medicine. This is unlikely or impossible with the other options.

### 5. Option 4

Four month runs in a) Medicine in General b) Surgery in General c) Community care (General Practice, A&M, drug and addiction) d) Emergency Medicine e) Psychiatry f) one other. General registration after 24 months.

#### a) Questions and comments

AMPA is generally happy with the idea of delaying general registration until the end of the second house surgeon year. AMPA is concerned about doctors entering A&M or General Practice after only one hospital year. Not many doctors do this, and removing the ability to do so would in AMPA's view make for safer care, at the small cost of removing a choice few doctors take.

The option creates an additional mandatory run, in Psychiatry. Council notes that aged care is to be emphasised in the new curriculum – does Geriatrics therefore have a claim to mandatory status? Are there other runs with similar claims?

#### b) Consequences

Doctors could have a Community Medicine experience that is too narrow to meet Council's goals. A doctor doing an Addiction run will not get a good understanding of General Practice.

Emergency Medicine and Psychiatry are given more importance than General Practice – all doctors must do an EM and a Psychiatry run but General Practice is optional.

## F. Which is your preferred option and why?

All options suffer from the weakness that a narrow, inadequate experience in Community Medicine is possible – by doctors doing Community Medicine runs in, say, Addiction, and not in GP or A&M. Option 3 seems to allow doctors to skip community medicine altogether.

AMPA's preferred option is its own one, given below ("Is there another option…").

Of the document's options, AMPA prefers option four, followed by option two, option one, and option three (as we understand it) a distant last.

Option four keeps doctors out of community practice until they have done two house surgeon years, and includes a mandatory community medicine run.

By comparison, option two can let doctors, in theory, out into community practice with two fewer runs than option four (psychiatry and one other) and eight months less experience and 'medical maturity'.

Option three, if we understand correctly, is similar to what exists now.

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## G. Is there another option that meets the discussion document's aims?

Looking at the strengths and weaknesses of each option, AMPA suggests the following

- **General registration after two years.**
- **THREE month runs in:**
  **a) General Medicine**
  **b) General Surgery**
  **c) General Practice or A&M Practice**
  **d) Emergency Medicine or Rural Hospital Medicine**
  **e) Psychiatry, Geriatrics or [other high-ranking branches as decided by Council]**
  **f,g,h) Three optional runs.**
- **No less that eleven weeks worked in runs a) b) and c).**

If Council is committed to four month runs, we suggest the following:

- **General registration after two years.**
- **FOUR month runs in:**
  **a) General Medicine**
  **b) General Surgery**
  **c) General Practice or A&M Practice**
  **d) Emergency Medicine or Rural Hospital Medicine**
  **e) Psychiatry, Geriatrics or [other high-ranking branches as decided by Council – perhaps a longer list than with the three month option]**
  **f) One optional run.**
- **No less that twelve weeks worked in runs a) b) and c).**

We see the advantages of this option as follows:

**1) Community runs are broad**

The community medicine runs are confined to General Practice and A&M (by excluding Addiction, Community Mental Health and any others), so ALL house surgeons will get a true and broad experience of community medicine. We think A&M is a good broad alternative to General Practice, which will give an excellent experience of urgent care in the community and some indirect experience of general practice – far more, we believe, than any other Branch.

The document notes that ideally all house surgeons would do a General Practice run (this is AMPA's thinking too), but there seem to be insufficient General Practice runs to go around (another argument for three months runs). A&M can provide around 100 house surgeon posts per annum, possibly more.

If and when there are enough General Practice runs to go around, General Practice could become a compulsory run by itself, and A&M bracketed with Emergency Medicine and Rural Hospital Medicine.

**2) Rural Hospital Medicine is included (bracketed with Emergency Medicine).**

RHM often includes emergency department work, and the experience is very broad, including ward and outpatient work. We think it is a valuable run in terms of Council's objectives.

We believe, as with A&M and General Practice, that shared-mandatory standing will give this under-doctored Branch a boost – house surgeons working in RHM may decide they like it and form ties to the Branch and the region.

**3) Safer system**

General registration is withheld until doctors have done two hospital years (see Locum and safety concerns – p4)

**4) Boost to key branches**

Shared-mandatory status is given to Psychiatry, and other branches that give house surgeons experience in Council's defined priority areas. The discussion document mentions "community care", "broad range of accident and illness", "age-related conditions", "prevention", "long term management" and "mental illness" as priorities.

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## IV. Conclusion

AMPA strongly supports Council in its plans to reform house surgeon training and is ready to do its part in offering house surgeon runs and training in Accident and Medical practice.

We are optimistic that the changes will provide better and more efficient training, with more training and care happening in the community.

Ultimately, we hope the changes will give better safer and more efficient and more convenient patient care.