Medical education into the future

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'The great aim of education is not knowledge but action.' – Herbert Spencer (1820–1903)

Introduction

Change in medical training in New Zealand is long overdue. A survey of first year postgraduate doctors working in Auckland showed a significant discrepancy between the skills expected and those attained.[1] New Zealand has the highest proportion of International Medical Graduates in the OECD – a poor reflection on the numbers of doctors being trained and retained in New Zealand.[2] Continued reliance on international medical graduates also raises another issue; the uncomfortable ethical position of New Zealand taking doctors from developing countries that have considerable need of such valuable human resources rather than training our own graduates. A study of 400 final year medical students and junior doctors found only 9% of respondents indicating a definite career interest in general practice with a further 21% indicating a possible interest.[3]

General practice is important for reasons of efficiency, equity and effectiveness in health care. Phillips and Starfield wrote: *'More than two decades of accumulated evidence reveals that having a primary care-based health system matters'* and cited research supporting better outcomes in heart disease, colon and breast cancer, reduced use of emergency departments, lower medication use and reduced health disparities particularly for areas with highest income inequality.[4]

Winds of change

Three papers published over the last two years will significantly shape the future of medical education in New Zealand:

- *'Fit for purpose and for practice'* published in May 2006 emphasised the medical workforce shortage in New Zealand.[5] We have the highest proportion of overseas trained doctors of any Western country and there is a particular shortage of general practitioners. Consequently many New Zealanders face difficulty accessing general practitioner services in rural and non-metropolitan areas. Suggestions were made for clinical placements to be configured in a way that would encourage future careers in community-based care and primary care. The importance of multidisciplinary teamwork was emphasised.
- *'Training the medical workforce 2006 and beyond'* published in May 2006 explored the imbalance occurring between service and education in training and drew attention to the increasingly limited exposure to learning opportunities experienced by senior medical students in hospital environments.[6] The report also criticised the traditionally limited rural health and primary health experience of our undergraduates and poorly structured training in the second year house officer positions. Limitations of the apprenticeship model in the current training environment were emphasised and new models such as competency-based training were recommended. Again, the inadequate numbers of graduates from our medical schools drew criticism.
- *'Reshaping medical education and training to meet the challenges of the 21st Century'* published in March 2007 proposes the establishment of a Medical Training Board to oversee all medical training in New Zealand.[7] The report calls for an increase in the number of graduates, for DHBs to be held more accountable for use of training funds, for development of a primary care–based undergraduate programme and for emphasis on competency-based programmes. More rural and regional experience in training and an emphasis on general practice training was recommended.

Opportunities presented

General practice is clearly the discipline most advantaged by the proposed changes. Organised general practice will be pivotal in development, support and delivery of high quality education. New models can,

and must be developed that allow more flexibility in both delivery of education and of service. Newly graduated doctors considering a career in general practice will have very different aspirations regarding lifestyle and working environment than those that general practice has traditionally offered. We must also remember that issues of future workforce capacity and teaching capacity are inextricably intertwined, and that the solution to workforce capacity lies in the ability to deliver high quality education and training.

Challenges

There are many shining beacons of both teachers and practices in the world of general practice training. However, such dedication and enthusiasm is not as prevalent as would be ideal. The universities have continual difficulties in finding positions in practices for undergraduate students. Space (a room that a registrar or student can use), time (adequate supervision of doctors and students is time consuming) and anxiety concerning competency to teach, all create tensions between what teaching capacity is needed and what is supplied. The financial reward from teaching has always been marginal – a disincentive to the more commercially-orientated practices and practitioners. With a proposed increase in registrar numbers, undergraduate training positions may become even more scarce.

Also, feedback from students reveals an occasional undercurrent of both negative self-perception and self proclaimed 'victim' status in general practice. This may poorly position the profession to take advantage of these proposed changes. The risk is that our profession is labelled as difficult, demanding and uncooperative whereas ideally the profession would be perceived as being solution-focused, proactive and cooperative. Contributing to negative self image are tensions between the traditional model of the owner-operated small business and the health environment that increasingly emphasises interdisciplinary cooperation, flat management structures and population-based funding. Owner-operator businesses can be highly flexible and efficient providers of care. They are, however, struggling under the demands of bureaucracy and have tended to amalgamate into larger units with support staff. Although either model is well capable of providing excellent training, larger practices may have difficulty in gaining the necessary 'buy in' from all practice staff and in reconciling short-term financial imperatives against long-term gains to the practice, to the profession and to the community that may occur from involvement in teaching.

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Co-operation between the College, the universities, communities and organised general practice is needed but may not occur, and the size of some providers (e.g. PHOs with small enrolled populations) may restrict their involvement unless they can ally with larger organisations. Strong leadership from within our profession will be required to forge the necessary alliances between groups that have not always worked co-operatively.

Conclusion

A unique opportunity has been presented that recognises the dynamic needs of health care and its workforce. Gorman, Scott and Poole from Auckland University commented on the future of medical education: '*The overwhelming conclusion is that to be appropriately effective in 2021 the health workforce will need to be differently configured and/or work differently.*'[8] The proposed shift in workforce training enables a raft of solutions to training and capacity problems in general practice. How this opportunity will be utilised is problematic and dependent on embracing change, ensuring cooperation between groups that have not always worked co-operatively, effective leadership and taking responsibility for the future of our own profession. The government, the tax payer and medical regulatory bodies will be watching our progress with interest.

Competing interests

None declared.

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