LETTERS TO THE EDITOR

To the editors,

I read with much interest Xaviour Walker's letter in your last issue. As an international student, I appreciate the worries he had regarding the availability (or lack thereof) of first–year jobs for New Zealand medical school graduates from overseas. It was pleasing to see the president of the New Zealand Medical Students' Association (NZMSA) voicing the very real, but often under-represented, claims and concerns of its international members.

Although frustrating for some, it can be understood how local students are given preference when it comes to job selection in their own country. What is disheartening however, and perceived by many to be an injustice, is the fact that international students are currently not eligible for the Trainee Intern (TI) grant.

I am perplexed, as are a number of my colleagues, as to why this is the case. We are full-fee paying students, which means that in the majority of cases we pay close to, if not more than, four times what New Zealand students pay in tuition fees. Moreover, our workload and responsibilities as TIs are the same as everyone else's. It seems only logical and fair, therefore, that we are also remunerated for work done. Although I acknowledge fully that the Trainee Intern year is our final year as students, and not one in which we work as doctors, I think most people would agree that the service provided in the health care sector by TIs is hardly negligible. Also, the grant which is designed primarily to assist in the paying off of student loans for locals will likewise go some way in easing the burden of expenses on foreign students.

The number of international students who are choosing to study medicine in New Zealand is on the rise, a testament no doubt to the quality of tertiary education available in this country. This should serve only to bolster the country's reputation and economy. I feel strongly, therefore, that the powers that be should look into changing the status quo with regards to the TI grant. As an international student, I do not expect to be afforded all the privileges available to New Zealanders. I suggest only that the Government consider this issue and indeed, if it is felt that the grant should still be reserved for local students, the tuition fees international medical students pay in their TI year could possibly be reviewed, and reduced, as some form of compensation. I urge the NZMSA to raise this matter with Government and seek change for the benefit of their international colleagues. Any move in this direction will certainly be appreciated.

Yours sincerely,

Robert Lopez
5th year medical student
CSM&HS

To the editors,

Junior Medical Staff teaching Medical Students

When I was a medical student I shared the prevalent view amongst my colleagues that house surgeons and registrars were a busy group of people who had wondrous amounts of knowledge but were too busy or unapproachable to try to get at. Now as a registrar I see the other side. Yes, I do have more knowledge than a medical student but this is just an inevitable consequence of being stuck in situations where one needs to recall the fact, attain the fact quickly or simply because my consultant asked me a question one day and I didn't know the answer so I looked it up for next time – a sort of augmented osmosis.

I love teaching medical students, they are keen in what you have to tell them (usually), and you can help them understand something that you yourself had difficulty with or something that everyone has difficulty with (neurology maybe).

I have heard colleagues say they don't have time to teach medical students, but that's uncommon. I have recently been rewarded, when a couple of fourth years on the ward were able to help with the round. My house surgeon was away and the senior house officer went off with one of the med students to see half of the patients, and the other one came with me and helped write the notes. Now that just sounds like slavery, but we had good dialogue about each patient and why I had chosen to change the antibiotics or why they were on such a small dose of heparin (DVT prophylaxis) and we all got something out of it. Now I don't mean to say that doctors are always looking to get something out of it. I was paid for teaching in my last job but I am not now and it doesn't change how much I teach. I think most junior staff teach because they see that they can make a difference.

If you want to get the most out of your registrar or house surgeon I would recommend (1) Asking questions, it seems an obvious but most don't and you are destined to be forgotten unless you ask questions. (2) Examining patients after they have been seen on the round, often patients have good signs and trying to remember to go back to them is fraught with obstacles, just stick your stethoscope on and have a listen then you can impress them by picking up the Austin-Flint murmur when the registrar missed it, and (3) You really don't realise how much you know, house surgeons/registrars and med students are often complementary in that a medical student often knows the book side of things better, so asking whether that ulcerative colitis patient has sclerosing colangitis can often send a shiver of déjà vu down the back of a house surgeon as they struggle to recall some long forgotten fact about the associated features of inflammatory bowel disease, so go on ask them…you won't regret it.

Yours sincerely,

Philip Robinson
Medical Registrar
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To the editors,

I was recently at the MLDS conference in Wellington. Insight into the recent RMO strikes was evident from both perspectives. From the RMO standpoint, more humane work hours were the most important factor, whereas from the DHB's perspective, such a demand is not economically viable. Reducing working hours per employee will need to be compensated by lesser pay and greater number of employees. There are already shortages of RMOs in the health system.

There needs to be an alternative to qualified physicians filling in the gap of shortages: Physician Assistants, a concept already in practise in places like USA. The qualification would require perhaps a 2 year diploma, at the end of which the person is able to do simple tasks such as: collect blood samples, fill out paperwork (to be signed off by a doctor), chase up the laboratory results, etc. These clerical tasks are already dreaded by every House Surgeon, who would prefer to be practising medicine. There would be a domino effect, starting from the House Surgeon up to the Consultant.

For example, House Surgeons would have more time to practise medicine, taking on more responsibilities off the Registrar. By having Physician Assistants, the health cost is lower (as they would not be receiving as much as a qualified doctor) and the working hours of a RMO is decreased. Hence, both the perspectives of RMO's and DHB's are resolved. Obviously, the solution may not be as simple as it appears; however, a feasibility study into such an option is definitely warranted.

Kind Regards,

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