

MedEd09

Investing in our Medical Workforce

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Summary

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Abbreviations and acronyms

AHW	Aboriginal health worker
AIDA	Australian Indigenous Doctors' Association
AMA	Australian Medical Association
AMC	Australian Medical Council
Bradley Review	Review of Australian Higher Education Report by Emeritus Professor Denise Bradley AC
COAG	Council of Australian Governments
CPMC	Committee of Presidents of Medical Colleges
CPMEC	Confederation of Postgraduate Medical Education Councils
DoHA	Australian Government Department of Health and Ageing
Garling Report	<i>Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals</i> , Peter Garling SC, October 2009
GP	general practitioner
IPE	interprofessional education
HWA	Health Workforce Australia
KPI	key performance indicator
L-TIPP	'Learning and teaching for interprofessional practice' project
MDANZ	Medical Deans of Australia and New Zealand
MEE	Medical Education England
MMC	Modernising Medical Careers (UK medical postgraduate training program)
MoLIE	More Learning for Interns in Emergency (training program in Queensland)
MSOD	Medical Schools Outcomes Database
NHHRC	National Health and Hospitals Reform Commission
NHWT	National Health Workforce Taskforce
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RPL	recognition of prior learning

Contents

Table of Contents

Background.....	5
Issues and recommendations	7
Summary of Recommendations	16

Background

Health care in Australia is currently facing a range of challenges. Our ageing population, population growth and changes in technologies will require new approaches to health care provision. Staffing shortages are being felt in many settings, especially rural, remote and outer metropolitan areas, and in a number of specialities, including that of general practice. To start to meet these challenges, there has been tremendous growth in training intake, with the number of new doctors graduating from medical schools set to more than double by 2012.

However, this rapid increase creates in turn a new set of challenges and pressures on hospitals, teaching general practices, postgraduate specialty colleges, and all other organisations in the sector. We must develop the systems and capacity now to ensure that we develop the health-care workforce that Australia needs in the future, and to ensure our world-class medical standards are maintained and improved.

The recent National Health and Hospitals Reform Commission report identified a key component of an agile and self-improving health system as a modern, learning and supported health workforce:

We believe that our health system should seek to optimise the dedication, diversity, energy and dynamism of our health workforce. Australia has a world-class approach to the education and training of this workforce. The people who care for and treat us comprise one of the major strengths of our health system. Our health workforce is responsible for the enviably high standard of health care that we enjoy in Australia. They are key agents of change, reform and innovation, driving continuous improvement in the delivery of health services at the coalface. And they are essential in monitoring whether our health system is achieving on its purpose of delivering better health outcomes for people. Accordingly, we want health system reform to be integrally shaped by the experience and knowledge of our health workforce, including clinicians and health system managers.

A Healthier Future for All Australians, National Health and Hospitals Reform Commission, June 2009

Hosted by Medical Deans Australia and New Zealand, MedEd09 was the third in a biennial series of national meetings aimed at advancing medical education in the two countries. It was sponsored by the Australian Government Department of Health and Ageing, the Australian Medical Council, the Committee of Presidents of Medical Colleges, and the Confederation of Postgraduate Medical Education Councils.

MedEd09 brought together approximately 170 representatives from Australian and New Zealand medical schools, medical colleges (most are trans-Tasman), hospitals, key medical organisations, the Australian Medical Council and Australian, state and territory health departments. There was also strong representation from the principal 'consumers' of medical education and postgraduate training including more than 15 medical students and 25 junior doctors. Against a background of several significant recent initiatives (including the report of the National Health and Hospitals Reform Commission, the recent negotiation of National Healthcare Agreements and National Partnerships in Health, and the National Registration and Accreditation Scheme for the health professions), the conference examined the issues and ideas around investing in our medical workforce.

The conference themes were:

- Increasing health workforce flexibility
- Achieving vertical integration
- Building training capacity

The conference involved expert presentations on a range of issues, as well as panel discussions and two sets of six breakout groups. The breakout groups discussed predefined issues and made recommendations back to the plenary group. The meeting benefitted greatly from the expertise and insights of Professor Sir John Tooke, the keynote speaker, who recently led the *Independent Inquiry into Modernising Medical Careers* for the United Kingdom Government.

At the end of two days, the conference used a KeyPad system so participants could anonymously vote on a series of issues and recommendations. In some instances, questions were modified 'on the fly' after voting by show of hands before being formally put to the vote via the KeyPads. Because there was only a short time before the voting session in which to formulate the issues and recommendations emerging during the meeting, it was agreed that participants could also email any additional suggestions in the week after the meeting, to be circulated for voting by email. Overall, the voting resulted in 17 recommendations emerging from MedEd09.

It should be noted that the constant theme in discussion over the two days, and one which underpins the final recommendations, was that governments and all stakeholders need to recognise the pivotal importance of education, training and research to a future sustainable health system and health workforce. Because of its importance, it was felt that this principle should be explicitly addressed in the planning and accountability frameworks for all aspects of current and future health system development.

What follows are edited summaries of the material covered in the individual presentations, the panel discussions and the breakout sessions.

Medical Deans will chair a small Implementation Group to prioritise and progress the recommendations. The Group will comprise representatives of the key organisations involved in the medical education and training continuum. We hope that the following summary of proceedings will provide a comprehensive basis for the bold and timely decision-making needed to sustain the high quality medical workforce of the future.

Emeritus Professor Neville Yeomans
Chair, MedEd09 Steering Committee.

Issues and recommendations

Investing in our medical workforce

The quality of our medical care is directly dependent on the quality of our medical workforce, who are in turn products of our medical education system. A well-planned, responsive, comprehensive, high-quality medical education system is therefore paramount in ensuring Australia provides high-quality and accessible health care to all people.

Recommendation 1

That this meeting advises the Australian Government that medical workforce capacity and training are critical issues for delivering quality health care.

Increasing health workforce flexibility

Generalism vs specialism

As well as general practice, Australia is in need of general specialists in a range of areas, including medicine, surgery, obstetrics, anaesthesia, and orthopaedics.

There is an increasing trend for medical trainees to select a sub-specialty, rather than remaining in a generalist or general specialist role. MedEd09 felt strongly that it is very important to encourage some of the specialist workforce to remain in general specialist roles, and that the disappearance of general specialists poses a risk to Australian health care.

The lack of generalism causes problems in a number of ways. Lack of generalism causes particular problems in regional areas, where the doctor is likely to see a wide range of cases. In hospitals, major trauma or comorbidity cases require a generalist approach to tackle multiple problems in a single patient. The ageing population will also require a more generalist approach, as older persons tend to have multiple health problems.

The transition of trainees into sub-specialties is driven by a number of factors, including the perception of generalism as being of lower status or involving more work, particularly in rural areas. Furthermore, the generalist is often less well remunerated (because the Medicare schedules particularly reward the carrying out of specialised procedures).

It is therefore important that generalism is seen as a path in itself, and that generalists are given the status, support and clear career pathways to make generalism an attractive option. Additional training options may also support this move. Generalism is a particular skill, and it is important that trainees are taught how to be generalists. Currently, trainee experience is mostly provided in major hospitals, which reflect the sub-specialty approach. More training provided by community health centres and regional centres will ensure that trainees are exposed to the generalist approach.

Recommendation 2

That state and commonwealth governments and medical colleges develop clear policies and strategies to promote generalist training pathways by the end of 2010.

Interprofessional learning

Interprofessional education (IPE) aims to build understanding between different members of the health care team, including different service levels and different specialties and sub-specialties. IPE is sometimes accused of undermining specialisations, but in actuality it is about collaborating and learning about each other, and about valuing and respecting each of the health disciplines.

There is an internationally recognised need for team approaches to health care, which are supported by IPE. It has been demonstrated that IPE leads to improved:

- workplace productivity
- staff morale (and hence retention rates)
- patient outcomes
- patient safety (lack of communication or miscommunication is major cause of adverse events)
- access (particularly in rural areas, the team approach helps patients get the care they need).

IPE can be incorporated at every level of medical education curricula to match learning objectives.

Geographic flexibility

Rural health care is a particular challenge in Australia. Fewer and fewer trainees are going to rural and remote locations, and many regional centres lack local doctors or comprehensive health care amenities. If the incoming numbers of students follow current trends of favouring cities and subspecialties, the crisis in rural health care will be accentuated.

The reinvention of the general specialist (Recommendation 2) will help to tackle this challenge; however, more is needed to encourage trainees to make the choice of a rural career. Research into the drivers for this choice shows that training in a rural setting is key to choosing a rural career. It is therefore vital that regional training models are developed, which will involve expanding the number of rural training places available, developing effective trainee educational supervision, and developing clear career pathways.

Regional health care, particularly for remote areas, may also require different health care approaches. Team health care, where delegated tasks are undertaken by mid-level personnel, may assist in many rural and remote areas where health care staff numbers are low. This approach creates a local workforce by training nonspecialists to work in a primary care setting instead

of bringing in specialists from elsewhere. The delegated tasks need to be carefully defined, but this approach has worked effectively in a number of areas in the Aboriginal Health Worker scheme.

Indigenous health is another major issue in Australian health care. Aboriginal people attend health care practitioners in far lower numbers than the rest of the population, often because of cultural barriers. Aboriginal people represent 3% of the Australian population, but only 0.3% of doctors and 0.6% of nurses.

To help to break down the barriers to Aboriginal health care, it is important that medical schools increase the numbers of Aboriginal health care personnel by recruiting and training more Aboriginal and Torres Strait Islander students. It is also important that all medical trainees are given some training and experience in Indigenous health, to expand awareness and skills.

Recommendation 3

That governments, colleges and Postgraduate Medical Councils develop models to increase pre-vocational and vocational training models in rural and regional areas in an integrated fashion.

Achieving vertical integration

Medical education continuum

The increased numbers of medical students has highlighted the need for coordination of medical education from the beginning to the end of student training and into workforce placement. MedEd09 saw the coordination of education across the continuum as of prime importance. The conference examined a range of issues, including:

Curricula (new roles emerge at every stage of the continuum; however, there is often a sudden transition to these roles. Do we need to teach some of the skills at the previous level so that the trainees will be better prepared?)

Teaching structure (would vertical structures teaching a number of levels at the same time be valuable?)

Research (how can we use the Medical Schools Outcomes Database to support the development of new educational models?)

Governance (who can coordinate and drive change across the continuum?)

It was felt that coordination and accountability between national and state jurisdictions for medical training is poor. It was further felt that medical education involved many different organisations, often leading to fragmentation and to the prominence of factional interests, rather than collaboration. Orchestration and communication, as well as co-development of policy between government sectors and between relevant organizations, was needed. It was felt that a single organisation was needed to oversee change, not to command but to facilitate collaboration, consistency and communication.

The establishment of Health Workforce Australia (HWA) is an important step forward in achieving this overall orchestration. However HWA's breadth of responsibility across a large number of health disciplines (many with needs different to those of medical training) and its limited scope (university students only) warrants a specific body for strengthening the coordination of medical training across the continuum. This body (perhaps termed Medical Education Australia) would need to work closely with and advise HWA. The governance arrangements would need careful thought: it might be successfully constituted as a major committee of HWA, reporting directly to the HWA Board; however it is more likely to achieve the community's and COAG's aims if it had an independent status similar to the Australian Medical Council Ltd.

The complexity of this area has led to the recommendation of a second smaller workshop to further explore the issues.

The utility of the Medical Schools Outcomes Database and Longitudinal Tracking Project (MSOD) was showcased to the forum. The value of this database to medical workforce planning for the future is now coming to fruition with the tracking of medical graduates through the early years of their pre-vocational and vocational training. The potential for linkage to other databases now being established as part of the NRAS and HWA is also recognized. However longer term funding commitment from the Australian Government is required to ensure the collection continues and maximum benefit of the investment to date is made.

Recommendation 4

That governments at all levels take immediate steps to address the gap between national and state jurisdictions in medical training.

Recommendation 5

That the Council of Australian Governments review the governance structure of Health Workforce Australia to ensure high level continuous national input from senior doctors responsible for training.

Recommendation 6

That there should be a combined approach to the Federal Minister for the creation of a Board to advise on coordinating training across the continuum.

Recommendation 7

That funding be provided to identify curriculum and other needs to facilitate the co-ordination of training across the continuum.

Recommendation 8

That a follow-up workshop be held between jurisdictions, universities, medical colleges, Health Workforce Australia, Postgraduate Medical Education Council, student representatives and the Australian Medical Council.

Recommendation 9

That MedEd09 endorses the continuation of the MSOD project, and urges the use of the database in the development of robust medical education and workforce models.

Competency, performance, time, simulated learning environments

Competency-based training is an approach to education that places emphasis on what a trainee can do once they have completed a program of training. For a trainee to be assessed as competent, they need to demonstrate the ability to perform tasks and duties to the expected standard. While ‘time’ is still the traditional measure mainly used to assess whether a trainee has completed their training, competency-based training is being explored in a number of areas to teach and test particular skills (eg psychiatry is successfully using this approach). It is particularly applicable to specific skills. Competencies may also be built on over time, with the development of first and second order skills at different levels.

There were mixed views however as to whether competency-based training suited some components (eg procedures) but not others such as higher order, integrated aspects of performance.

It was also recognized that there is no clearly shared understanding of the term ‘competency based training’.

Interest was expressed at the MedEd09 conference in the use of simulated learning environments (SLEs) as a useful tool to provide ‘real-world’ scenarios and test performance. SLEs allow trainers to include a wide range of variables in the training and testing scenario. Protocols can be developed to test specific skills, clinical reasoning and overall performance when additional challenges are included. Developing SLE measures to robustly measure performance instead of skill-set competence may usefully expand education capacity and quality.

Recommendation 10a

That an evidence - based approach be adopted to clearly define and inform the optimal use of both competency and experiential (time-based) approaches to medical education and training within an integrated education system.

Recommendation 10b

Where such evidence does not exist, support should be made available for the required research and development.

Recognition of prior learning

Workforce flexibility is supported when trainees can move between regions, between countries, and between specialties. Workforce and lifestyle changes mean that trainees no longer expect to stay in one position for many years.

It is therefore to our benefit to facilitate this movement to meet the needs of the workforce and to ensure we have committed and inspired doctors. The recognition of prior learning (RPL) allows trainees to move between geographical areas and between specialties without losing credit for the training they have already achieved.

While some colleges have RPL schemes, in general it is ad hoc and applying for RPL is often laborious for the trainee. A coordinated and consistent approach is needed from colleges to support this important tenet of workforce flexibility. RPL schemes should:

- be transparent, accessible, reproducible
- fit with the curriculum
- guarantee principles of equality, fairness and natural justice
- have clear criteria against which applicants are assessed.

Recommendation 11

That an approach be made to CPMC to develop workable models for recognition of prior learning during vocational training, which (i) are transparent, accessible and reproducible (ii) fit with their curricula (iii) guarantee principles of equality, fairness and natural justice and (iv) have clear criteria against which applicants are assessed.

Building training capacity

The rapid increase in the number of medical graduates will place great pressure on the colleges and hospitals that provide further training. To ensure that education standards are maintained, it is vital that training institutions continue to have the capacity to provide high-quality education to increased numbers of trainees.

Recommendation 12

That governments ensure that training institutions are appropriately resourced, to ensure essential infrastructure for effective training is available in all environments.

Physical capacity

One aspect of training capacity is simply the physical space in which trainees can learn. It is important that we use all the resources currently available — including public and private health centres — as well as developing new resources. Teaching space should be incorporated into the design specifications of all new health facilities.

Clinical capacity

Clinical training is currently delivered primarily in major hospitals. However, a number of problems have started to arise in this approach, which will only be exacerbated by increased trainee numbers.

Supervision and mentoring is clearly important for trainees to be able to learn from more experienced doctors. However, the mismatch between consultant hours and trainee shift-work breaks down the relationship between senior and junior doctors and creates an imperfect learning experience. Changing patient protocols that encourage short stays and rapid movement between specialties also mean that trainees find it difficult to 'follow' a case, and miss out on longitudinal patient management. Finally, service provision in hospitals is primarily done by junior doctors, so they need to balance the tension of dividing their time between patient needs and their training needs.

MedEd09 recognised that what is needed is a change in the system to allow training to be delivered in different settings, including the private system and community health centres. These represent significant resources in health care, and need to be harnessed for the future of health care training in Australia. This will provide the capacity needed for the influx of students, and will also provide a broadened and improved training experience for trainees. As we look to the future, it is probable that the proportion of medical care that is delivered through hospitals will fall, so expanding students' exposure to other health care delivery models and centres will be invaluable in ensuring they can deliver this care. Innovative approaches to education such as Queensland's very successful MOLIE (More Opportunities for Learning in Emergency) program, may also improve the learning experience.

Understandably, involving the private sector will require some mechanism to compensate private doctors involved in the program. It will be valuable to research how this is achieved by other countries that do involve the private sector in medical education.

It is also vital that the importance of medical education is recognised. At the moment, there is a divide between service delivery and training; a cultural shift is needed to bring them together under a shared philosophy. Service institutions need to include education as part of their mission and agree that education and service are equal and part of a continuum of activity.

At the same time, institutions need to educate the community about the importance of medical education, so that patients see training as an accepted part of service delivery to ensure quality of care into the future. This will need to be matched with education of trainees to improve their communication with patients and so patients are not seen as just a 'teaching experience'.

Recommendation 13

That all levels of government (with relevant stakeholders) should develop clear strategies and policies by the end of 2010 that permit training to expand into private and other settings.

Recommendation 14

That governments at all levels, through the Council of Australian Governments, ensure that coupling between service delivery and training is achieved.

Educational supervision

The expansion of medical education into the private and community sectors needs to be matched by an expansion in our concept of who the trainers are. MedEd09 strongly expressed the idea that a culture shift was needed to make every doctor a teacher, and to acknowledge teaching as an important part of everyone's role. Achieving this shift requires a number of changes.

First, it was recognised that acting as a trainer and supervisor requires expertise, time, and accountability. In the clinical setting in particular, it is important that supervision is acknowledged and supported, most especially through allocated time being given to supervision, rather than it just being part of normal duties. Most clinicians enjoy training: research shows it prevents burnout by helping to maintain interest and commitment. However, support is crucial to maintain this interest and to ensure education is not 'squeezed out' by service pressures.

Key performance indicators based around education may be needed on an institutional basis to ensure that time and support for training are built in to service models. By including educational goals in performance review processes for clinicians and administrators, the importance of the activity will be recognised and measures will be developed to meet the KPIs.

Second, in looking at future supply of doctors, we should realise that we will also need a future supply of educators. We should therefore ensure that this expectation and training in teaching are made part of the current curricula, so that trainees emerge with this understanding. We also need to explore the capacity for all levels to be trainers and educators for the level below, or even using fast learners as peer teachers.

Third, better training of supervisors will improve the performance and standing of this key group. The development of a national medical education qualification would provide valuable professional education for clinicians. A modular training course would allow clinicians to use the time they had available, and those trainers with a Masters of Medical Education or similar could act as leaders within their institution.

Finally, an important aspect of training was the recognition that 'clinical reasoning' — bringing together many facets of knowledge and skill to arrive at a diagnosis and treatment — was of prime importance in the training of a high-quality medical workforce. Clinical reasoning is critical to patient care, and protocols are no substitute for this higher level cognizance.

Unfortunately, currently students are too often expected to learn clinical reasoning simply by observation. We need to ensure that our trainees acquire the critical skills of clinical reasoning. We need to equip supervisors with the knowledge and skills to unpack their own thinking and be able to explain this to students and give structured feedback, so that students learn the reasoning process. Dedicated professional development of clinical teachers would allow them to optimise their time with trainees and explicitly pass on the knowledge and skills of higher clinical reasoning.

Recommendation 15a

That jurisdictions and employers ensure 'teaching and training' are essential requirements in job descriptions, and support, encourage and reward the clinicians for teaching.

Recommendation 15b

That jurisdictions and employers ensure that 'teaching and training' performance are key performance indicators to be addressed at annual appraisal of their medical staff.

Summary of Recommendations

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