



AMA

Submission to

Department of Education, Science and Training

Medical Education Study

Medical Education in Australia – What makes for success in medical education?

March 2006

Australian Medical Association
PO Box 6090
KINGSTON ACT 2604
Ph:(02) 6270 5400
Fax:(02) 6270 5499
Email: workplace@ama.com.au

Summary:

- Any changes to medical education need to be made with the aim of ultimately improving the health care of Australians.
- Undergraduate medical education should not aim to produce interns, it should aim to lay the foundations to produce exceptional doctors and leaders in medicine.
- Undergraduate medical courses should provide a broad base from which the medical graduate can develop a career in any type of medical practice.
- Transition into internship can be improved by ensuring medical students have adequate levels of clinical exposure in their undergraduate years, that hospitals conduct comprehensive induction programs for new interns, and interns are provided appropriate supervision, support and resources.
- Broad clinical experience is important in ensuring doctors have the knowledge to treat patients in a holistic manner. Graduates need time to gain clinical experience through direct patient care before moving into postgraduate training.
- A coordinated approach is needed in planning for the increased numbers of medical students and graduates. This needs to be expedited. Current resources are inadequate and need to be bolstered.
- Clinical teachers need to be valued and rewarded appropriately and educational time needs to be protected for all doctors.

Detailed comments:

Preserving the Quality of Medical Education:

Medical education needs to be approached as a continuum. Medical education cannot and should not be fragmented. Learning continues throughout the career of a medical practitioner, building on the solid foundation of knowledge gained firstly from the undergraduate, then prevocational and postgraduate years. Undergraduate medical education based on a list of competencies required for internship presents the serious risk of overlooking the important elements of medical education. While a well-defined curriculum is important, if it is too narrow and short-sighted in its design it is likely to promote the achievement of a number of competencies at the sacrifice of a deeper understanding of methodology and underpinning knowledge.

The AMA would be seriously concerned by any moves to fragment medicine through the development of curricula that simply serve to meet a set of minimum standards for the various stages of medical education. Developing such minimum standards only serves to reduce the quality of our medical graduates. This approach will not produce the leaders in medicine that the medical community and community at large need and deserve.

What ‘competencies’ a junior doctor requires to function effectively at that particular stage of their career (i.e. internship) are not necessarily representative of what they will need for future practice. We need to be aiming to produce exceptional doctors, not just average interns.

Any changes to medical education need to be with the aim of ultimately improving health care of Australians, and should not be made as a reaction to the increased numbers of

medical school students and graduates, or to produce graduate doctors in a shorter time frame in an attempt to counter workforce shortages.

Key Elements of Undergraduate Medical Education:

Undergraduate medical courses should provide a broad base from which the medical graduate can develop a career in any type of medical practice. It should also aim to produce junior doctors who possess the knowledge, skills, attitudes and potential that best serve the changing health needs of the Australian society.

Undergraduate medical education should:

- i. include broad concepts of health, of health education and of the prevention of ill-health;
- ii. promote an understanding of human development, health and disease through the acquisition of knowledge of the appropriate physical, biological and behavioural sciences;
- iii. integrate the basic sciences with clinical and behavioural sciences;
- iv. provide an understanding of the importance of the doctor/patient relationship in medical care;
- v. value the apprenticeship model of medical education and use alternative teaching methods (simulation) as additional to this;
- vi. provide patient contact early in the medical course;
- vii. include teaching within and outside hospitals;
- viii. contain a component dealing with Aboriginal health;
- ix. include early and continued exposure for medical students to rural practice;
- x. include elective terms;
- xi. teach research methods;
- xii. instruct students on peer review, emphasising its importance in medical practice;
- xiii. be structured on the premise that all stages of medical education are related and that they will be followed by postgraduate training and continuing education in every discipline; and
- xiv. promote an awareness of the many aspects of law and ethics relating to medical practice.

Transition to Internship:

The transition of a medical school graduate into internship can be improved by ensuring that students are provided with adequate clinical experience throughout their undergraduate medical training. Medical students should be included as members of the hospital/clinical team wherever possible, be assigned an appropriate level of responsibility, and be actively included in the team's educational and review activities. Not only does this provide students with the learning opportunities that they need to develop their clinical knowledge, it also demystifies that function of the unit team, better preparing students for their first day of internship.

Interns need a well-planned and comprehensive induction to their new work environments. The hospital should provide necessary structures and resources to ensure interns feel supported and feel able to seek assistance whenever required. The promotion of a 'teaching culture' with protected teaching time is essential in our teaching hospitals.

The Importance of the Prevocational Experience:

Australia is renowned for producing high quality medical graduates. However, these graduates require a strong prevocational training experience. The AMA maintains the view that the prevocational period, the time between graduation from medical school and commencement of specialty training, is an essential time in the development of a junior doctor and must be valued and supported.

Time spent with patients and with mentors cannot be replaced by fast track teaching methods or by a 'tick a box' approach. Graduates need time to be inducted into professional practice and need time to develop those attributes and skills that only come from time spent with direct patient care and through mentoring by senior clinicians. There is already an abundance of information to be absorbed by a medical student in their undergraduate years. Quality should not be compromised by the push to graduate 'ready made' doctors who will ultimately lack the breadth and depth of clinical experience required to deliver quality medical care.

It takes time for the vast majority of junior doctors to make a decision as to the specialty they will pursue. The recent AMWAC report 'Career Decision Making by Postgraduate Doctors,' revealed that only 18% of doctors decide on the specialty they will pursue by the end of their medical school training; the vast majority not making their decision until PGY2 (two year after medical school) or beyond. This decision making time is important and should be preserved. Junior doctors need to be exposed to a variety of specialties, not only to assist them make robust career choices, but also to ensure that they gain the necessary general experience that will provide a sound foundation for their specialist career.

These pre-vocational years allow the medical graduate to develop their skills in a number of areas of medicine including Emergency Medicine, Surgery and General Medicine. This experience is essential if we are to maintain the high quality, holistic approach to medical education. The AMA views with caution any attempt to develop prescriptive medical school-style curricula for prevocational training. Current work on a national core curriculum should result in a guide for development and assessment, not a set of assessable requirements that would effectively create another formal hurdle for doctors-in-training without necessarily adding any value to their professional development and skills as medical practitioners. The intent should remain the creation of useful learning opportunities and outcomes through direct patient care and clinical experience.

Impact of Role Substitution on Medical Training:

Now more than ever, we need to maintain the quality of our medical graduates to ensure they are prepared for the demands that will be placed on them by the ever changing health needs of the Australian population and changes to the delivery of health care. Maintaining a holistic approach to medical education is increasingly important, as it is essential that doctors are able to continue in their roles as leaders and coordinators of the care team. Further fragmentation of health care will be detrimental to health outcomes.

While it is the view of the AMA that graduates are currently reasonably well prepared for their internship, there is a very real threat that this could be jeopardised by a lack of

investment in clinical teaching and hospital resources, and through the increasing push for nurses and other health professionals to take over some of the tasks performed by doctors.

If medical roles are delegated to non-medical staff it is likely to have a detrimental impact on the training and skills maintenance of medical students and doctors. It is essential that doctors remain highly skilled in procedural functions to allow them to manage the most complex of patient cases. The potential impact of nurse practitioners and task substitution on medical training is of particular concern given the significant increase in medical school graduates in the coming years.

Planning, Infrastructure and Resources:

The AMA has long been concerned with regard to the inadequate planning for the increased numbers of medical school students and graduates. AMA analysis of future medical school places indicates that by 2008 the intake of medical school students will be in excess of 2400 per annum. By 2012, we estimate that medical school output will have grown by around 90% compared to 2000. Clearly, existing resources and infrastructure will not be able to cope with these increased numbers of students and graduates and quality clinical experiences will be spread very thin.

The AMA has called on state and federal governments to commence planning immediately to ensure that adequate resources and infrastructure are in place to cope with these increased numbers. It requires a planned, gradual build up of resources and infrastructure and the provision of adequate funding and resources to the overloaded health system. This planning needs the cooperation of all jurisdictions.

The quality of medical education is at risk due to the desire to push through increased numbers of doctors without the availability of quality clinical opportunities and placements. There is already evidence of this occurring. Queensland Health is considering removal of the emergency term for interns due to a shortage of adequate emergency placements for the number of interns in the State. This approach is clearly detrimental to the medical education of these interns. The AMA surveyed Queensland doctors and 95% of respondents reported that the emergency term is essential and should be a compulsory part of internship. The answer is to bolster resources to accommodate the increased numbers - cutting clinical experience is unacceptable.

Service Delivery Vs Clinical Education:

A balance must be maintained between service demands, teaching and professional development. Our hospitals are also resource starved. There is ever increasing pressure on hospitals to deliver more with less. The obsession with service delivery at all costs is dangerously shortsighted and ignores the long-term benefits of ensuring that our doctors have access to proper training and education.

The continued loss of clinical teachers is a serious concern for the future of medical education. Clinical teachers need to be supported to ensure that they have the time to deliver high standards of supervision and teaching, uncompromised by time and resource constraints. Clinical teaching also needs to be valued and rewarded appropriately. Education and support must be provided to clinical teachers to ensure that they are able to perform effectively in their roles. Focussed teaching and education time needs to be

protected for all doctors. While clinical teaching is an obligation of the medical profession, it is not possible in an environment where service delivery obligations are so great that time for clinical teaching is continually squeezed and is increasingly allocated a thinner slice of the pie.

Conclusion:

Australia has a strong history of quality medical education. Our doctors are welcomed throughout the world. Our system has been based on strong professional control of standards, the development of a strong general skill base, and a strong learning environment. This environment is now under increasing pressure with the loss of clinical academics and the reality that public hospitals and health departments are obsessed with service delivery at the expense of recognition of their teaching responsibilities.

There appears to be unnecessary pressure to move towards competency based training (CBT) for the medical workforce. A key criticism of CBT is that strategies are needed to bridge the gap between competence and excellence. Medical education should not be about simply “falling across the line.”

CBT can encourage fragmented learning and a checklist approach that ignores the holistic assessment of competence and assessment of underpinning knowledge. The transition from medical school to specialist training programs must ensure that doctors have a strong general skill base including key skills required to enter a vocational training program. Education programs must ensure a life-long commitment to learning. These goals can only be ensured when the environment for learning is properly resourced and teaching is properly valued and recognised.

References:

Australian Medical Association. The Challenges of Training Doctors in their Early Postgraduate Years. Presentation to Postgraduate Medical Council Forum, Perth. November 2005.

Australian Medical Association Position Statement: Prevocational medical education and training 2005.

Australian Medical Association Position Statement: Rural and Remote Health 2001.

Australian Medical Association Response to the Productivity Commission's Position Paper on Australia's Health Workforce, November 2005.

AMWAC Career Decision Making by Postgraduate Doctors - Summary of Findings, November 2005.

Karle H. Current Problems in Medical Education. World Medical Journal 2005; 51: 71-72.

Lake F R. Teaching on the run tips: doctors as teachers. MJA 2004; 180 (8): 415-416