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National Health Workforce Taskforce
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Dear Madam/Sir

Re: Australian Medical Association submission to the National Health Workforce Taskforce discussion paper on the governance and organisation of clinical training

Thank you for the opportunity to provide feedback on this discussion paper. As the AMA does not engage directly in the planning, organisation or management of clinical training, our comments are restricted to the general issues raised in the discussion paper as they relate to medical education. The AMA's views on a national approach to data collection on clinical placements were outlined in our submission to the NHWT in February 2009.

Before providing any detailed comments, it is worthwhile highlighting that there is some confusion over the focus of the discussion paper, and indeed the scope of the NHWT's work, in so far as the discussion paper appears to cover both undergraduate clinical placements and provides commentary on areas such as specialist vocational training. This submission contains comments on the implications of the discussion paper across the medical education continuum.

It is essential for medical students to spend time in clinical settings in properly supervised roles to develop the clinical skills they need to practise safely and effectively as interns, and lay the foundations for lifelong learning and further prevocational and vocational training. Clinical placements provide essential clinical and professional learning opportunities to students by enabling them to gain experience in treating patients and to mix with peers.

Clinical placements are therefore fundamental to producing a well-rounded and highly skilled medical practitioner. This is currently recognised by the Australian Medical Council (AMC) in its standards for accrediting medical schools and college training courses. Clinical placements must meet the national standards prescribed by the AMC. This ensures that Australia's high standard of medical education is maintained and that the education and training experiences provided by universities and medical colleges across Australia meet nationally consistent, internationally recognised standards.

Further, in respect of undergraduate, prevocational and vocational education, the role of identifying appropriate clinical placements must remain in the hands of universities, postgraduate medical education councils, and medical colleges respectively because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at undergraduate and vocational levels.

The AMA recognises that Australia faces a huge challenge in finding sufficient clinical training places for medical students because of the current expansion of medical school places. Increased student numbers in nursing and allied health is also adding to this pressure. In addition, a number of jurisdictions are trialling new types of health professionals such as physician assistants, resulting in more competition across professional groups for clinical training opportunities within health services.

The AMA has consistently called for additional funding to support undergraduate clinical training and to that extent the AMA welcomed the extra funding for clinical training that was announced during the Council of Australian Governments (COAG) meeting in November 2008. The challenge now facing policy makers is to ensure that this funding goes to where it is most needed and not into new bureaucratic structures and processes.

Prevocational and vocational training

While the thrust of this discussion paper focuses on undergraduate training, there is significant concern that the principles are likely to apply to prevocational and specialist vocational training. If this is the intent of the NHWT then it should say so and provide a more detailed discussion paper that acknowledges the significant role of the postgraduate medical councils (PMCs) and the medical colleges in medical education. The medical profession requires clarity on how the PMCs and the medical colleges will interact with the new national health workforce agency and assurance that their existing roles will be maintained in full.

Prevocational training

The current postgraduate medical education infrastructure provides a bridge between the medical schools and medical colleges. The PMCs set the standards for prevocational medical education and training in Australia. They are strategically placed to understand and influence changes in the health workforce and are in a good position to enable change in the medical profession. The PMCs bring valuable experience to postgraduate medical education through their work in the national accreditation of prevocational education, clinical teaching and curriculum development.

The AMC is investigating the feasibility of establishing a process for reviewing and accrediting the PMCs. The AMA supports the AMC assuming the external accreditation role because it would:

- improve the continuity of medical education and training by increasing the AMC's links with the middle stage of medical education and complement its roles of accrediting basic medical education and vocational/specialist training,
- assist with the introduction of the Australian Curriculum Framework and the Prevocational Medical Education Framework, which if implemented properly, will improve education and training outcomes for PGY 1 and PGY 2 doctors,
- heighten recognition at the national level of the importance of prevocational training, and
- provide increased transparency of accreditation practices.

The likelihood of the AMC taking on the external accreditation of the PMCs would be thrown into doubt under the principles and arrangements outlined in the discussion paper. The PMCs' pre-eminent role as the bodies responsible for the first two postgraduate years and non-vocational trainees must be preserved and supported with adequate levels of resources by state and territory governments. This will ensure that PGY 1 and PGY 2 placements are of

high quality, that equivalent and consistent training experiences are provided in hospital and other health settings across Australia, and that they provide the nationally consistent, essential precursor training experience required for further study at the vocational level.

Vocational training

The specialist medical colleges set standards and conduct training for specialist vocational training in a cost-effective manner focusing on safety and quality. Much of the work of the colleges is delivered by committed individuals who are passionate about increasing safety and quality within their discipline. These people give their time freely or at a far lower cost than would be available to other bodies. The colleges are also engaged in partnerships in education for their trainees, particularly with universities accredited by the college to provide components of training or professional development.

None of the proposed models refer to or integrate any involvement of the medical colleges who have for many decades successfully supported or provided specialist medical training and have been responsible for setting the highest standards for this training, including approving appropriate vocational training placements. This role must remain in the hands of the medical colleges to ensure that clinical placements at the vocational training level are of high quality, that they provide equivalent and consistent training experiences in hospital and other health settings across Australia, and that they properly complement the course requirements at the vocational training level.

The role and operation of the national health workforce agency must not interfere with the role of medical colleges in:

- accreditation and standard setting,
- determining specialist qualifications held by medical practitioners,
- approving and in many cases managing professional development programs for the medical profession, and
- assessment of overseas-trained specialists who are applying for recognition to practice in Australia.

Role of a national health workforce agency in clinical education and training

The discussion paper suggests that the new national health workforce agency could take the form of a central workforce planning agency that would be tasked with linking the health and education sectors; overseeing the development of a multi-disciplinary and competency-based training framework for health professionals; managing clinical placements; and managing funding arrangements for clinical training. Under this model many facets of medical education and training would be effectively controlled by a government agency.

This model would not improve the governance and organisation of clinical training in Australia. A nationally consistent structure for maintaining the high standards of education and training for the medical profession already exists under the auspices of the AMC. The AMC is the independent national standards body that accredits medical education and training and maintains standards to protect patient safety. Within this framework, the AMC has in place standards that underpin undergraduate clinical training as well as processes to encourage medical schools to work with each other collaboratively so that available resources for clinical training are utilised effectively.

The role of the AMC is consistent with policy principles set down by the World Federation for Medical Education (WFME).¹ The WFME guidelines are very explicit on this topic, requiring that the accreditation of medical education (including the component of medical education that takes place during clinical training placements) should ensure that quality assessment is independent of government, the medical schools and the profession, and that the accrediting body (in this case the AMC) should be authorised to set standards in respect of medical education and training, including clinical training.

Patient safety and public confidence in the system will be supported by sound assessment and recognition processes. Training placements must also offer a satisfactory range and scope of training. Training numbers are just one element: appropriate standards are essential.

A continued and important role for the AMC has not been acknowledged in the discussion paper and none of the proposed models suggest a role for the AMC as it functions currently.

The proposed model presented in the discussion paper could undermine the independence of the AMC and establish a framework where the current standards for medical education and training could be eroded and manipulated. This would undermine Australia's hard won reputation for excellence in medical workforce training and risk international recognition of students who undertake medical education and training in Australia.

Further, any governance model that compromises the effective and independent role of the AMC will not be supported by the medical profession on the basis that quality of patient care could be compromised. The role of accrediting medical education and training, at university, prevocational and college level, must be fully delegated to a body with medical professional expertise and the support and confidence of the profession, such as the AMC.

The accreditation body must remain independent from any outside influence, including from influence or interference in its decisions by all levels of government or any government established body such as the new national health workforce agency, in undertaking the following activities:

- setting of standards,
- ongoing accreditation of individual education and training courses, and
- assessment processes for international medical graduates.

Notwithstanding the need for the AMC arrangements to remain independent, it is important to highlight the fact that the existing AMC council and standing committee arrangements are highly accountable and transparent, including through the following processes:

- the Commonwealth and the jurisdictions (Australian Health Ministers' Advisory Council) are represented on the council and its major standing committee (currently by a representative of the Commonwealth Chief Medical Officer and the Chair of the Health Workforce Principal Committee),
- health consumers are also represented on the council, its standing committees and accreditation assessment teams,

¹ World Health Organisation/World Federation for Medical Education *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005).

- medical boards are represented on the council, standing committees and (periodically) on accreditation assessment teams,
- medical students and trainees are members of accreditation standing committees and accreditation assessment teams,
- medical schools and specialist accreditation reports are made public and are available through the AMC website,
- recognition of medical specialties reports are made available to the Commonwealth Minister of Health and are also made public when the Minister has decided on the outcome,
- there are comprehensive appeals mechanisms for all of the AMC assessment activities,
- all assessment criteria and examination specifications, including statistics on pass rates, are published on the AMC website and are available in hard copy from the AMC,
- the AMC has produced comprehensive reference publications that detail the content and assessment criteria for all AMC examinations, together with detailed commentaries on clinical best practice in the Australian context, and
- a number of the AMC's processes are subject to external validation and/or compliance with international standards, such as the approval of the medical school accreditation process by the US Federal Department of Education and compliance with WFME guidelines.

Current arrangements which allow individual jurisdictions to have some input into the work of the AMC through the arrangements outlined above are appropriate in helping ensure that local workforce issues are drawn to the attention of the AMC. However, it would not be appropriate for either the Australian Health Ministers' Conference itself or the new national health workforce agency to seek to influence unilaterally the national standards set by the AMC for medical education and training across the country.

There is also a high risk that the national health workforce agency would result in extra layers of administration and bureaucracy that would soak up valuable resources and have little understanding of local needs. It is hard to imagine, for example, how a national health workforce agency would be able to assess the resources available at the local level or leverage local relationships to expand clinical training opportunities for medical students into the private sector and into community settings.

Apart from the important role of collecting data on clinical training capacity for informing future workforce planning, a national health workforce agency should focus on ensuring that adequate funding is available to support universities in their efforts to place students in high-quality undergraduate clinical placements. Universities and local health service providers are best placed to understand local needs and already work effectively together with other local stakeholders.

The national health workforce agency could assist in improving the overall coordination of undergraduate clinical placements by encouraging more cooperation at the regional or statewide level. The AMA believes that there would be some merit in establishing consultative mechanisms that provide a forum for universities, health departments and other stakeholders to work together to develop plans that support a strategic approach to the effective provision and resourcing of undergraduate clinical placements.

Critically, it should not be the role of the national health workforce agency to control or in any way micro-manage the allocation of individual clinical placements, and/or the content and structure of clinical placements. This role must appropriately remain in the hands of the universities who are the best position to ensure that clinical placements complement their courses at the undergraduate level.

The AMA would strongly oppose such an interventionist role. These types of changes would undermine the professional learning environment and potentially impose changes on the structure of medical school programs and curricula. These changes would diminish Australia's high standards of medical education.

The most appropriate model for delivering sustainable clinical training and ensuring that the needs of students are met is where education providers coordinate arrangements for clinical training with health providers at the local level. Medical schools are best placed to ensure that:

- students are exposed to a range of models of care and to an appropriate range of clinical disciplines,
- the length of clinical placements meet local requirements and are consistent with the medical school's curriculum, and
- sufficient clinical teaching and learning resources, including appropriate supervision, are arranged for clinical placements.

This approach is consistent with the AMC's standards for accrediting medical schools, which encourages medical schools to work collaboratively with other schools, clinical placement sites and state and territory health departments to provide a high-quality clinical experience for their students.²

Multi-disciplinary and competency-based training

The AMA suggests a cautious approach to implementing multi-disciplinary health education and training as described in the discussion paper. Multi-disciplinary training is effective for medical students when the standard of teaching and training is at the level that will be required for the future medical practitioner's scope of practice. In reality, multi-disciplinary training is likely to be applicable to medical students at a very basic level only, as medical training quickly becomes more intense, detailed and extensive than the other health disciplines.

The AMA supports medical students being able to gain experience working in teams with other health professionals, as well as developing a good understanding of their roles, but it does not want to see changes that could undermine the high standards of medical training in Australia.

Similarly, competency-based training and assessment has limitations in its application to medical education. Medical education needs to be approached as a continuum and should not be fragmented. Learning continues throughout the career of a medical practitioner, building

² Australian Medical Council, *Assessment and Accreditation of Medical Schools: Standards and Procedures 2009*.

on the solid foundation of knowledge gained firstly from the undergraduate, then prevocational and vocational years.

There is much that is learned and developed through non-competency measures. In particular, effective clinical judgement can only be developed progressively using a number of different competencies and significant clinical exposure.

Competency-based training is often seen as a model to shorten training. In fact, training may be shorter or longer depending on the capability of the trainee.

The AMA would be 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.

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 shortsighted in its design, it is likely to promote the achievement of a number of competencies at the sacrifice of a deeper understanding of the methodology and underpinning knowledge.

In one of the proposed models, a central agency would decide the adequacy and length of competency-based training. The AMA does not see this as an appropriate role for a national health workforce agency.

The AMC is working with stakeholders to improve medical workforce training and is actively looking at the extent to which multi-disciplinary and/or competency-based training are appropriate and relevant in medical training. The AMC should be left to continue this work as the body responsible for accrediting medical education and training in Australia.

Relationship between the provision of medical services and clinical training

The potential conflict between workforce/service provision and quality education/training is a significant issue that has not been covered at all in the discussion paper but requires consideration and careful handling. Doctors in training make a significant contribution to the provision of medical services in the health sector and to the teaching and supervising of more junior members of the team, as well medical students. As a result, there are significant advantages for service providers in having secure training numbers and length of contracts for trainees. Shortening or lengthening training time is a challenge for hospital and community health planning.

Training in medicine cannot be separated from the provision of medical services, both in terms of the contribution that doctors in training make to the provision of medical services, and the contribution that fully qualified doctors make to the training of medical students and trainees while they provide medical care and supervision. Any proposed restructuring must continue to recognise and integrate both these aspects at an educational and resource level.

Medical profession input into the national health workforce agency

The AMA understands that the broader governance and structure of the national health workforce agency has not been decided. While it is not a topic of the discussion paper, the AMA would reinforce that it must include appropriate mechanisms that provide for strong professional input into its activities.

Workforce planning

Previous workforce planning agencies such as the Australian Medical Workforce Advisory Committee (AMWAC) were able to capture professional input effectively and there was broad stakeholder support for the work of agencies such as AMWAC. The health professions are now largely excluded from workforce planning processes and very little now appears to be happening in this area. There is a lack of accountability in current workforce planning activities and deep suspicion about the workforce agenda being pursued by various jurisdictions.

Enhancing community-based training

There is a significant opportunity for further community-based training for undergraduate, prevocational and specialist vocational medical training and for other health professionals; however, investment in community infrastructure for this training will be required. The AMA would welcome early consideration of this issue by the new national health workforce agency.

Recommendations

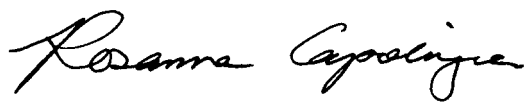
In summary, the AMA believes that:

- future governance arrangements for clinical training must not undermine the role or independence of the AMC, PMCs or the medical colleges,
- the existing roles of the AMC, universities, PMCs and medical colleges in clinical training should be maintained and supported, not taken over by, the national health workforce agency,
- the future role of the national health workforce agency should focus on ensuring that funding arrangements adequately support universities to negotiate clinical placements at the local level,
- the role of the national health workforce agency should not involve micro-managing the allocation of individual clinical placements, which should continue to be done by universities in respect of undergraduate training because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at the undergraduate level,
- in respect of prevocational and vocational medical education, the role of identifying appropriate clinical placements must remain in the hands of PMCs and medical colleges respectively, because they are in the best position to ensure that clinical placements are of value and properly complement the education and training programs that they deliver at the prevocational and vocational levels,
- the national health workforce agency could assist in improving the overall coordination of undergraduate clinical placements by fostering cooperation at the regional or statewide level between educational institutions and health care providers,

- competency-based training and assessment has limitations in its application to medical education, as much needs to be learned and developed through non-competency measures,
- the potential conflict between workforce/service provision and quality education/training is a significant issue that requires consideration and careful handling, and
- the national health workforce agency must include appropriate mechanisms that provide for strong input from the medical profession into its activities.

The AMA looks forward to participating in the upcoming forums that will discuss the matters raised in the discussion paper.

Yours faithfully

A handwritten signature in black ink, reading "Rosanna Capolingua". The signature is written in a cursive style with a large initial 'R'.

Dr Rosanna Capolingua
President

30 March 2009