Australian Medical Council Limited

Review of the Accreditation Standards for Primary Medical Programs

ATTACHMENT C Consultation questions template: Proposals for detailed changes

Your feedback

We would **like to hear your perspectives** on the proposals for detailed changes. We will consider all the feedback we receive when shaping further proposals for change.

The AMC's primary responsibility is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community and the final content of the Accreditation Standards for Primary Medical Programs (medical school standards) must reflect this. If you would like further information about how to engage with the review please visit the AMC website.

We are seeking feedback by **Monday 24 October 2022.**

To enable efficient evaluation of the feedback our preference is for responses to be provided, by email, in a **Word document** using this **template** to standardsreview@amc.org.au. If this is not possible, please provide a non-protected PDF.

This template

This template provides questions against each major theme of the standards review, across the:

1. Graduate Outcome Statements
2. Standards for medical schools

This template should be read in conjunction with the **Consultation paper - Review of Accreditation Standards for Primary Medical Programs proposals for detailed changes**, which outlines the background and review process, the feedback and recommendations received during the scoping consultation, and the AMC responses in the form of proposed revisions to the standards and outcomes. Feedback is sought on the proposed revisions to the standards and outcomes and on any additional considerations for this review.

The full set of proposed outcomes and standards are contained in the other attachments:

- **ATTACHMENT A**: Proposed Graduate Outcome Statements – Draft for consultation August 2022
- **ATTACHMENT B**: Proposed Accreditation Standards for Primary Medical Programs – Draft for consultation August 2022

The questions are only a guide, please advise of anything that you think the AMC should consider around the detailed proposals. We recognise that not all suggested questions below will apply to all stakeholders, please only respond to those that are of relevance to you. There are also spaces for general comments.

Your information

Organisation (if relevant)	Australian Medical Association (with significant input from the AMA Council of Doctors in Training)
Name	
Position	
Location (State/Territory)	
Email	
Telephone number	

1. Graduate outcomes statements

Content of the graduate outcome statements - Questions
1. *Social Accountability* In the area of Social Accountability, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
The proposed revisions appropriately identify social accountability outcomes required for safe and competent medical practitioners at the beginning of practice. Further recommendations to be considered include: • Revising proposed statement 3.5 to read '*Apply health advocacy skills* ***where appropriate*** *by partnering with patients and their families/carers, and/or communities to define and highlight healthcare issues, particularly inequities*.' • Revised proposed statement 1.2 to read '*Apply whole of person care principles in clinical practice, including consideration of a patient's physical, emotional, social, economic,* ***environmental****, cultural and spiritual needs and their geographic location.*' • Amend proposed statement 3.2 to read '*Explain the social, cultural, personal, physical and environmental determinants* ***(including climate change)*** *of health for individuals and communities.*' Further, the graduate outcome statements can be enhanced through slight amendments similar to ones made in the previous prevocational standards update of the domain introductions to incorporate climate change as an important factor influencing health now and into the future. • The introduction of Domain 3 is amended to read '*Domain 3 describes the graduate who recognises the diverse needs of patients in communities across Australia and Aotearoa New Zealand, understands the underlying social and environmental determinants* ***(including climate change)*** *of health and can apply strategies that address health inequities for individual patients, communities, and populations.*' AMA also calls for the inclusion of a new standard reading: • '*Equip current and future health professionals with the knowledge, values, confidence and capacity to provide environmentally sustainable services to current and future patients.*'
2. Cultural Safety In the area of Cultural Safety, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required? Do you have any further comments on this area?
The AMA commends the AMC Aboriginal, Torres Strait Islander and Māori Standing Committee Subgroup for their work in developing clear cultural safety standards. The AMA suggests the following revisions for clarity and conciseness: • Removal of the second sentence to proposed standard 3.4 to read '*Demonstrate an understanding of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal, Torres Strait Islander, and Māori Peoples*.' The first sentence already succinctly summarises the intention of the now removed second sentence. • Revised phrasing of proposed standard 3.5 to read '*Demonstrate an understanding of the structural barriers to accessing healthcare services and apply strategies to mitigate the impact of these,* ***notably for population groups with inequitable health outcomes including, but not limited to: Aboriginal and Torres Strait Islander and Māori Peoples, migrant and refugee populations, patients with a disability, and patients to identify as LGBTQIA+ and other.***' The revised phrasing allows for the standard to be

encapsulated within one clear and unambiguous sentence. Further, the abbreviated term LGBTQIA+ is an accepted term referring to people identifying as lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other diverse sexualities and/or genders.

- Edit proposed standard 4.3 into two distinct standards. Proposed standard 4.3 as it currently reads contains two clear outcomes and the creation of another standard will assist medical graduates to practice in a culturally safe manner. The first standard would be '**Demonstrate an understanding of Aboriginal and Torres Strait Islander and Māori models of healthcare including community and sociocultural strengths**' and the second separate standard would be '**Describe best practice approaches that lead to sustained Aboriginal and Torres Strait Islander and Māori people's health and wellbeing outcomes**.'

3. Safety and Quality

In the area of Safety and Quality, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA supports all efforts to include patient safety and medical graduate wellbeing within these standards. However, particular care must be used when using concise standards to convey issues around social and emotional wellbeing in a de-stigmatising manner. The AMC must strongly consider the following wording of proposed statement 2.6:

- '*Demonstrate awareness of factors that affect their personal wellbeing and recognise and respect their own limitations to mitigate risks associated with professional practice. This will include **seeking support when needed and** following the **relevant** advice of a **trusted** health professional to **support graduates deliver safe and high-quality patient centred care**.*'

The suggested revisions take a de-stigmatised and strengths-based approach to the standard's language. The AMA Council of Doctors in Training have received considerable anecdotal evidence where a treating medical practitioner has managed doctor in training wellbeing poorly. Standardising graduates to follow the advice of a health professional may become an issue as health professional advice is not unimpeachable – sometimes advice is not in the best interest of the patient and/or conflicts with other advice. For example, a treating health practitioner may advise that a period of leave is in the best interests of a doctor experiencing burnout, but this is not necessarily a requirement for safe practice and may instead be addressed through other actions including reducing overtime, changing jobs, or addressing the meaningfulness of work with a supervisor.

Further, the safety and quality revisions can be enhanced through the following amendments:

- Revising proposed standard 2.16 to read and include '*Contribute to **psychosocially** safe and supportive working and learning environments, including **adherence to and enactment of** policies and processes regarding bullying, harassment, racism and discrimination*.' The inclusion of the phrase 'adherence to and enactment of' clearly signals the expectation of graduates to embody and apply practices that are safe and supportive. Relying only on graduate awareness or knowledge does not transpire to actions, or behaviour and cultural change. Inclusion of the term psychosocial safety ensures graduates are aware and models expectations of a workplace that successfully manages the risks of psychosocial hazards.
- Editing proposed standard 2.7 to read '*Manage their time, education and training demands and show ability to prioritise workload to manage patient outcomes and health service functions.*' The revised wording removes 'be punctual' as the phrase is excessive considering 'managing their time' includes being punctual.

4. Emerging Technologies

In the area of Emerging Technologies, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA recommends the following amendments reflecting the need for health care systems to become sustainable and climate conscious:

- Proposed standard 3.7 is revised to read 'Explain and incorporate sustainable evaluation practices in common population health screening, disease prevention and health promotion approaches in public health.'

- The inclusion of a new standard reading 'Identify opportunities for increased sustainability of practice by using emerging technologies where they are clinically appropriate and in line with patients' preference'

5. *Partnering with Patients*

In the area of Partnering with Patients, do the proposed revisions to the outcomes identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA recommends the following amendment:

- Revise phrasing in proposed statement 1.4 to read '*Communicate with patients and their families/carers, adapting communication styles and modes relevant to patients' health literacy and other needs.*'

This revised phrasing removes the words 'level of' when referencing health literacy. No predefined levels of health literacy exist and the use of 'level of' implies a prejudicial hierarchical perspective. Additionally, the proposed statement has been rephrased to make "communication" the key competency rather than 'adaption of communication.'

Structure of the graduate outcome statements - Questions

6. *Specificity of Outcomes*

Are the proposed revisions to the outcomes appropriately specified at a high level? If not, what further revisions might be required?

Do you have any further comments on this area?

The proposed statements are at a sufficiently high level of achievement, described as expected actions and behaviours using "apply", "demonstrate" and "perform" in each domain. This level of expectation is appropriate for the professional, social and cultural expectations of medical practitioners.

7. *Order of Domains*

Do you agree with the re-ordering of the outcome domains? If not, what else should the AMC consider?

The ordering of domains is appropriate however, it is imperative that Domain 1 remains in the first position. Domains 2-4 may be ordered in any other order after Domain 1 in any future iterations. If changed, would still be suitable to the profession.

2. Standards for medical schools

Contents of the accreditation standards for medical schools - Questions

8. *Social Accountability*

In the area of Social Accountability, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA suggests the following amendments to simplify and provide greater clarification within the standards.

- Revise phrasing of proposed standard 1.1.3 to read 'The medical program commits to developing doctors who are competent to practice safely, **sustainably** and effectively under supervision as interns in Australia or New Zealand, and who have the foundations for lifelong learning and further training in any branch of medicine.'
- Revise phrasing of proposed standard 2.3.3 to read 'Students are provided with opportunities to develop an understanding of the differing needs of diverse patient groups, **to integrate knowledge of systemic disadvantage, power differentials, and historical injustices into their practice, and to appreciate that there are patients for whom there are** systemic barriers to health equity. This includes, but is not limited to Aboriginal, Torres Strait Islander and/or Māori people, LGBTQIA+ people, people with disabilities, culturally and linguistically diverse people and those from varied socioeconomic backgrounds.'
- Revise phrasing of proposed standard 5.2.5 to read '*The medical education provider applies appropriate recruitment, support and training processes, that champion diversity, for patients and community members engaged in planned learning and teaching activities.*'
- The inclusion of a new standard reading '*The curriculum includes specific, evidence-based content on LGBTQIA+ health, which is and is led and authored by LGBTIQA+ health experts or in collaboration with LGBTIQA+ people, integrates lived experience, and includes content on inclusive practices and depathologisation*.'

9. *Cultural Safety*

In the area of Cultural Safety, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA suggests the following amendment:

- Rephrase proposed standard 2.3.7 to read '*The medical education provider assures that learning and teaching throughout the program is culturally safe, and informed by Aboriginal and Torres Strait Islander and/or Māori knowledge systems and medicines.*' the clarified and revised language ensures ensure accountability of the standard falls upon the medical education provider.

10. *Student Wellbeing*

In the area of Student Wellbeing, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA welcomes the inclusion of a new standard on an overall strategy to support student wellbeing and inclusion but can be enhanced and actioned through the following revision.

- Proposed standard 4.2.1 is revised to read '*The medical education provider implements a strategy across the medical program to support student wellbeing and inclusion**, and publicly report progress on this strategy.***' Simply codifying intentions, awareness or knowledge within the standards does not transpire to action or behaviour and cultural change. To ensure medical education providers are meaningfully

developing, implementing and supporting student wellbeing and inclusion there must be an accountability mechanism.

Further, to ensure meaningful action on student support and wellbeing the following elements must be included:

- Proposed standard 4.2.7 is revised to read '*There are policies and safe reporting mechanisms for all learning environments that effectively identify, address and prevent bullying, harassment, racism and discrimination**; and report on the extent to which these are addressed***.' Similar to the above, reporting actions encourages meaningful behaviour and culture change.
- The creation of an additional standard adopting a risk-based approach to providing psychosocially safe working and learning environments for all students and staff
- The creation of an additional standard calling for medical education providers to develop and implement suicide postvention policies, strategies and programs. While there is rightfully increased attention and investment in suicide prevention, there is an unfortunately a need for greater resourcing of suicide postvention strategies and policies to compassionately support and respond to bereaved friends, colleagues, supervisors, and teachers. Suicide is often unexpected, with an immediate impact on friends and colleagues.

The following inclusions regarding flexible learning policies are suggested:

- Proposed standard 4.2.5 is amended to read '*The medical education provider **develops and** implements flexible learning policies **relevant to the students' individualised needs, in pursuit of supporting student success. This includes but is not limited to provisions such as access to flexible study and leave arrangements, and cultural leave***'

The intention of the suggested amendments specifies the need and purpose of flexible learning policies and reiterates the need for actions and policies to be tailored according to each students' need. Further the inclusion of 'develops' ensures the onus of creating support systems and policies on medical education providers and is not the sole responsibility of the student with needs. The revised phrasing also approaches flexible training with strengths-based language.

Other considerations:

- Proposed standard 5.1.3 is amended to read '*The medical education provider works with health services and other partners to provide amenities to support learning and wellbeing for students on clinical placements, including reasonable access to accommodation near placement settings.*' Removal of unnecessary words.

11. Transition to Practice

In the area of Transition to Practice, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA and AMA Council of Doctors in Training strongly advocates that:

- Standard 4.2.4 is amended and revised to read '*The medical education provider:*

  *i. Implements a safe process for **voluntary** medical student self-disclosure of information required to facilitate additional support and reasonable adjustments within the medical program*

  ii. ***Ensures that appropriate privacy and confidentiality protections are implemented, and any information disclosed is only shared with relevant stakeholders with the medical student's permission.***

While the AMA recognises the intentions of enabling medical self-disclosure of medical student needs, supports, and reasonable adjustments; there are concerns that mandatory self-disclosure of wellbeing issues may inadvertently stigmatise students. The culture of medicine has unfortunately not progressed to a state where medical students and young doctors can trust institutions and some unscrupulous supervisors to keep sensitive personal information confidential. It only takes one individual to carelessly publicly disclose a medical students wellbeing issue in a workplace

leading to student stigmatisation. Self-disclosure can only occur when a psychosocially safe culture and workplace is developed and maintained over an extended period of time. Further the onus on providing, developing and implementing reasonable adjustment must not fall on the medical student requiring support.

The AMA encourages medical education providers to prepare students for transition to practice in an a deliberately planned, timed and appropriate manner. Ideally of which would be broader than a term and in a field that is relevant to the scope of Australian medical intern practice.

12. Governance, Leadership and Resources

In the area of Governance, Leadership and Resources, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

The AMA and AMA Council of Doctors in Training advocates for greater inclusion of medical students within medical education provider governance. This can be reflected through the following amendment:

- Proposed standard 1.3.1 is amended to read '*The medical education provider has a documented governance structure that supports the participation of organisational units, staff,* ***medical students,*** *and those delivering the medical program in engagement and decision-making processes*.'

The effective and valued inclusion of medical students within decision-making and governance processes enshrined in standards will enhance educational outcomes, medical student wellbeing, and safety.

Further in proposed standard 1.3.4, it is stressed that effective support of students to participate in the governance and decision-making of their program includes an environment that is genuine and welcoming, representative structures and known and visible across the student cohort, and representation in these structures are facilitated meaningfully and inclusively. These elements should be explained and expanded in the Standard's Notes.

Other amendments to the proposed standards AMA recommend include:

- Proposed standard 4.1.1 is revised to read '*The size of the student intake is defined in relation to the medical education provider's capacity to resource all stages of the medical program* ***and according to medical workforce demand and supply projections***.' Medical student intake and output should not only be determined by provider capacity and resourcing but also community need and training pipeline sustainability.
- Proposed standard 5.1.1 is amended to read '*The medical education provider has the educational facilities and infrastructure to deliver the medical program and achieve the medical program outcomes.* ***This includes facilities and infrastructure supporting the learning of medical students with additional needs and supports.'*** Medical education providers must provide the appropriate infrastructure and facilities to support the diversity of medical students such as parents, carers, people with diverse genders, people with disabilities, and those with religious and cultural needs. For example, feeding and change room for parents and carers of young children.
- Proposed standard 5.2.1 is amended to read '*The medical education provider recruits and retains* ***suitably qualified*** *academic staff necessary to deliver the medical program, given the number of students and mode of teaching and learning.*'

13. Outcomes, the Curriculum and Assessment

In the area of Outcomes, the Curriculum and Assessment, do the proposed revisions to the standards identify what is required for safe and competent medical practitioners at the beginning of practice? If not, what further revisions might be required?

Do you have any further comments on this area?

Reflecting the current maldistribution and shortage of medical professionals, the following amendment is strongly suggested:

- Proposed standard 2.2.1 is amended to read '*There is purposeful curriculum design* ***delivered in an integrative way that supports generalism*** *based on* ***medical workforce supply and demand, community needs, and*** *a coherent set of educational principles and the nature of clinical practice.*'

The inclusion of 'medical workforce supply and demand' and 'community needs' reflects medical curriculums' need to be responsive to emerging workforce trends. These inclusions should also encourage a fair distribution of medical professionals and specialists across diverse geographies and community settings.

Further, to support medical student wellbeing and ensure greater educational outcomes the following revisions are suggested:

- Proposed standard 2.3.1 is amended to read '*The medical education provider employers a range of* ***evidence-based and relevant*** *learning and teaching methods.*' The term 'fit for purpose' as stated in the original proposed standards while appropriate can be enhanced with the bolded term.
- Proposed standard 3.2.1 is amended to read '*Students are provided with timely* ***and regular*** *feedback on their performance to guide their learning.*' The term regular should remain within the proposed standards. Regular and timely feedback is key to effective teaching and learning.
- Proposed standard 3.2.2 is edited to read '*Students who are not performing to the expected level are identified* ***as early as possible and are*** *provided with support and performance improvement programs in a timely manner.*' To support medical student educational outcomes and wellbeing, underperforming students should be identified and supported as early as possible. The inclusion of 'early as possible' reinforces the role of medical education providers to regularly and actively evaluate student learning.
- Standard 3.2.3 is revised to read '*The medical education provider* ***and medical students*** *give feedback to supervisors and teachers on student cohort* ***and supervisor and teacher*** *performance*.' Medical students should be empowered to provide 360 feedback to meaningfully enhance their learning.

14. Emerging Technologies

Do the proposed revisions to the standards identify the requirements on education programs that graduate safe and competent medical practitioners in the area of Emerging Technologies? If not, what further revisions might be required?

Do you have any further comments on this area?

15. Innovation

Do the proposed revisions ensure that the standards are able to continue to support innovation within medical schools?

Are any further revisions required?

The following amendment is suggested for ease of readability and clarity:

- Standard 6.1.1 is revised to read '*The medical education provider continuously evaluates and reviews its medical program to quickly and effectively identify, evaluate and respond to concerns, risks and quality changes of educational innovations including curriculum content, quality of teaching and supervision, assessment and student progress decisions.*'
- Standard 6.1.2 is reordered to read '*The medical education provider regularly and systematically seeks and analyses the feedback of students, teachers, staff, health services and communities, and uses feedback to continuously evaluate and improve the program*.'

16. International Frameworks

Do the proposed revisions to the standards meet the requirements under relevant international frameworks? If not, what further revisions might be required? Do you have any further comments on this area?
The following amendment is suggested: • Proposed standard 2.2.10 is amended to read 'There are opportunities for students to pursue studies of choice that promote breadth and diversity of experience **relevant to population and/or community need(s)**.' The inclusion of the phrase 'relevant to population and/or community need(s)' reflects that medical learning should be relevant to the needs of the Australian population not only occur at the complete interest of the emerging practitioner. Learning that is tailored to a particular subspecialist field may not meet the generalist needs of the community.

Structure of the accreditation standards for medical schools - Questions

17. *Re-grouping of Standards*

Are the proposed revisions to the structure of the standards conducive to streamlining reporting and conceptually linking aspects of a medical education program? If not, what else should the AMC consider?

18. *Increase Focus on Outcomes*

Do the proposed revisions effectively balance an increased focus on outcomes with process and input focused standards?

The change to outcome-based standards aligns with tertiary education standards, including as graduate outcomes. The ramifications of this is relevant for both medical education providers and students, as this structure toward 'outcome-based standards' is readily interpreted, applied and relevant to the stakeholders. Moreover, outcome-based standards are more readily measured as opposed to standards from other perspectives.

19. *Reintroduction of Notes*

Which standards might benefit most from greater clarity around implementation and best practice?

The reintroduction of Notes will assist medical education providers to provide best practice educational outcomes to medical students. The AMA recommends the following standards are clarified within the notes:

- Student wellbeing especially standard 4.2.5. Medical education providers should be provided suggestions and discussions around the implementation and development of flexible learning policies.
- Notes for standard 1.3.4 within governance, leadership and resources can expand on how to facilitate meaningful medical student participation within organisational and educational governance structure. Proposed standard 1.3.3 could also be expanded within Notes to explain which governance groups can appropriately provide effective academic oversight. Further, notes for Standard 5.1.1 can provide examples and a discussion around appropriate facilities and infrastructure to assist medical students.

Summary questions

20. In your view, are there any areas of change which might be challenging for medical schools to implement effectively? If so, please explain what areas might be challenging and why.

21. Are there any **further significant areas** in which the AMC should consider revisions to the graduate outcomes and the standards for medical schools?