Health LEADS Australia –
a draft Australian Health Leadership framework

AMA Council of Doctors in Training:
response to consultation questions

1. Does Health LEADS Australia encapsulate the leadership capabilities needed to achieve the best outcomes for consumers, health workforce reform and the health system as a whole?

The Health LEADS framework is a high level document that adequately reflects the generic capabilities for leadership. The competencies described are good in principle with solid descriptors for each of the key areas.

Of most interest to the AMA is how the framework will be incorporated into undergraduate, prevocational and vocational medical education and training programs and in accredited professional development.

If the objectives of the proposed leadership framework are to be realised, a plan must be developed to operationalise its intent, with buy in from all stakeholders. Such a framework should be of practical use and offer tangible benefits to junior and senior doctors.

It is the practical application of this framework into existing frameworks, many of which already contain the elements identified in Health LEADS, that will represent the greatest challenge to its implementation.

This will require leadership to be recognised, supported and rewarded within the health system and across different health care settings, such as public and private settings. Equally important, health system governance structures and processes must allow health leaders to raise new ideas and action them and must not stifle innovation because it is seen as too difficult, inconvenient or irrelevant.

2. How can Health LEADS Australia work with frameworks and leadership development activities relevant to the medical profession?

As indicated, many existing medical education, training and professional development frameworks also focus on the capabilities outlined in the Health LEADS framework. These include but are not limited to:

- Australian Medical Council accreditation standards for medical schools and specialty colleges;
- Australian Curriculum Framework work for Junior Doctors (ACFJD);
- CanMEDS Physician Competency Framework; and
- Specialty medical college professional development requirements.
It will be important for Health Workforce Australia to work with these bodies and leverage off these frameworks, to ensure that the Health LEADS framework complements and is incorporated into existing frameworks.

3. How can Health LEADS Australia be incorporated into early career education and training, and into accreditation for continuing professional development?

Again, dovetailing with the AMC medical school and specialty college accreditation standards, the ACFJD, and existing professional development structures will ensure that there is impetus for the development of these skills in the early career of medical officers and beyond.

It is far more difficult to arrange formal opportunities and activities for busy junior doctors to engage in that are not regarded as onerous or dismissed as irrelevant/unnecessary by the junior medical officer population. Informal comment from doctor in training members also suggests that an online course/competency program is likely to be seen as a barrier rather than an enabler to actually developing these skills.

Other feedback suggests that forums such as the Future Health Leaders conference run by Health Workforce Australia last year, represent good opportunities for the development of these skills in a practical manner outside of a formal professional development program.

Clearly, many of these competencies are already relevant to medical students and medical school is often a great place to be able to learn and develop these skills in a multi-disciplinary fashion. It is likely that competencies such as leadership could be taught via interprofessional education (IPE). While the AMA is supportive of IPE in undergraduate training, it is considered less suitable as the training requirements of postgraduate doctors becomes more specific.

Central to IPE is an understanding, respect and appreciation of professional boundaries and expertise. All too often, political correctness, multiple hierarchies, competing egos and sensitivities, and the drive for task substitution from other professions influences interprofessional interactions in health.

The development of leadership capabilities is an important aspect of medical education and training as junior doctors often assume the role of team leader with accompanying medico-legal responsibilities. In this respect, sometimes leadership skills are presumed but may not be well developed. It is vital that doctors develop the leadership skills to acknowledge other roles whilst not relinquishing their own for medico-legal reasons.

4. What resources or further development are required to optimise the usefulness of this framework?

The AMA recommends that further work be undertaken to establish whether there is an evidence base to support the link between the development of leadership competencies, IPE, improved professional practice (IPP) and better patient outcomes.
While the World Health Organization’s Framework for action on IPE and collaborative practice cites evidence for the benefits of IPE including improved access to and coordination of health services, better use of specialist resources, and improved health outcomes for people with chronic disease, a Cochrane review of the impact of interprofessional collaboration on professional practice and health care outcomes found only five studies that met randomised controlled trial (RCT) inclusion criteria.

There will also be a need to find ways to engage junior doctors on the usefulness of the framework by making it relevant to their everyday practice. Many feel as though they have too many things to ‘tick off’ in order to complete internship already.

Finally the success of the implementation of this framework will require national agreement and effort. It will also depend on adequate resourcing to enable doctors to be released from their clinical service roles including the provision of appropriately qualified staff to temporarily backfill positions, and quarantined and remunerated time from service delivery for professional development in addition to training and teaching requirements.

Other related AMA policy that may be useful to inform the development of this framework includes:

- AMA Position Statement: Local Lead Clinician Groups – 2011
- AMA Position Statement: Role of the Doctor – 2011
- AMA Position Statement: Doctors’ engagement in the management of hospitals – 2010
- AMA Position Statement: Medical Professionalism – 2010

Yours sincerely

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