Confederation of Postgraduate Medical Education Councils

Submission to the National Health Workforce Taskforce

Clinical Training – Governance and Organisation

Introduction

The Confederation of Postgraduate Medical Education Councils (CPMEC) is the peak body for State and Territory Postgraduate Medical Councils (PMCs) or equivalent in Australia. CPMEC notes that the NHWT paper focuses principally on undergraduate clinical training arrangements. In this connection, CPMEC and member PMCs are anxious about the need for explicit recognition of the vertical integration of medical training and the implications for prevocational training arrangements, as the system moves towards national registration and accreditation in 2010.

In this connection, the impact of increasing numbers of undergraduate students together with the increasing number of prevocational doctors is going to require careful and rigorous modelling of clinical manpower and patient services to enable medical students and junior doctors to receive quality clinical experience. CPMEC is concerned that increased numbers, if not managed at all levels of training, could have a negative impact on clinical experience. Other health students will also require similar clinical time and the problems will be exacerbated if not addressed systemically.

In relation to the discussion questions raised in the NHWT paper titled *'Clinical training – governance and organisation'*, CPMEC would like to make the following comments. Tight time frames to respond to the paper have meant that internal consultation with our membership has been somewhat limited.

Experience in Clinical Training Planning, Organisation & Management

All Postgraduate Medical Councils play a critical role in the clinical placement of prevocational trainees. This includes accreditation of Postgraduate Year 1 (PGY1) internship training positions as a prerequisite for general registration with Medical Boards. Most PMCs also manage the internship allocation processes. Increasingly, many PMCs are now also undertaking accreditation beyond PGY1 to ensure quality of training, supervision and performance for all those in the first two years of prevocational medical training. In addition, a number of the PMCs are now committed to the assessment and upskilling of International Medical Graduates who laterally enter the medical workforce and are not part of any vocational college training program. The net effect is that there is considerable expertise within CPMEC

members in relation to clinical training planning, organisation and management.

More recently, member PMCs have been engaged in a series of initiatives to address the pressure on clinical placements for prevocational trainees that will arise from increased medical and health student numbers with flow on effects for prevocational training. This stems from the concern of CPMEC that high quality prevocational medical education and training completes the undergraduate professional experience and provides the foundation for subsequent specialist and general practice training. Prevocational doctors also play a key role in the operation of health services. Their numbers will expand significantly over the next few years and require careful management to maintain safe care.

Initiatives have included introduction of new rotations; development of rural specialist pathways; building resourcing models to support existing and future clinical placements; identifying alternative settings for internship and prevocational training; and considering ways of building supervisory capacity. All of these cannot be separated from the needs of undergraduate clinical training.

Strengths and weaknesses of governance models presented

CPMEC would favour something like the Facilitative model as the best of the models proposed but its efficacy would depend on the details of implementation. Funding should go with the trainees to support time for supervision, infrastructure and simulation facilities. The proposed Agency could lend its support and establish system wide frameworks to organisations seeking to improve the efficiency and effectiveness of clinical training arrangements.

CPMEC is not supportive of central management of regional or site placements as this is heavily dependent on local knowledge and contacts. We have been advised that there is evidence that central agencies have not worked in a number of other countries. As an illustration, reference has been made to the Clinical Training Agency in New Zealand, which is considered by most stakeholders to not achieve useful outcomes. An agency may be valuable for defining best practice, policy, innovation, communication, feedback and advice, but not implementation. Anecdotal evidence suggests that centralised placements, even at a jurisdictional level, such as in Western Australia and Victoria have not always worked, and effectiveness improved when done between a local area health service level with all universities needing placements in that area. In some cases in the past, there have been difficulty achieving agreement in local areas, but this is improving as policies and guidelines are being developed. Spare clinical training capacity is also best identified locally. In similar vein, data collection has been extremely difficult without local input.

Further, additional layers of reporting requirements should be avoided if at all possible if they do not add significant value to the training process. There is also further evidence required to demonstrate effectively that the multiple roles suggested for a national agency would be better than done by individual agencies.

CPMEC would also urge caution in using the same models developed for different clinical disciplines and training environments.

Support for Clinical placement management by new agency

CPMEC would see the proposed new Agency's role to be strategic, focusing on developing an overall framework for clinical training which addresses barriers to placements – both hospital and ambulatory – and develops system level plans to overcome these barriers. This may include such things as better coordination between levels of training and between clinical disciplines; creating disincentives for cost shifting; providing support for clinical skills laboratories; improved remuneration for clinical supervisors; and incorporation of training KPIs in health service funding agreements.

The Agency should also have close and regular consultation with educational providers and placement sites. In this connection, the Agency could support other national organisations that could facilitate this regular contact. CPMEC would reiterate the need to build partnerships with existing structures rather than duplicate them. It should also encourage regular interface between academic and clinical service staff as happens in some jurisdictions.

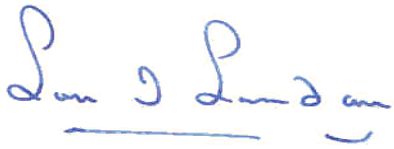
Titles of placements may not indicate the breadth or depth of competencies achieved within and across professions and national models of clinical placements could not be based on these titles alone.

It must also recognised that the desire to move towards achieving competencies, as proposed, is already a feature of AMC accreditation of posts. In this regard, the new Agency must take cognisance of the varying needs for each health profession.

Opportunities to improve governance and organisation of clinical education in Australia

Recently there has been a spate of reports making recommendations for restructuring clinical education and training in Australia. They include the National Registration & Accreditation Scheme, the Garling enquiry in NSW, and the National Health and Hospitals Reform Commission report. The Agency could play a lead role in facilitating discussions to improve coordination and integration where they do not seem to be working well and support those areas where it seems to be working well. In medicine, placements are well audited by professional bodies. Similarly, there is a significant level of coordination through the Medical Training Review Panel.

The issue of having a larger number of undergraduate students as well as prevocational trainees is going to stretch the current training environment. It will become important that clinical service staff are even more involved in the delivery of training and this needs to be reflected in job descriptions and performance management systems. It may provide an opportunity for more innovative approaches and solutions to training. It will also require an overt recognition of training and supervision as a key role not only within teaching hospitals but across all health services.



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