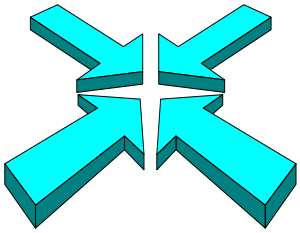
# Confederation of Postgraduate Medical Education Councils



## Submission to the Review of the Medical Training Review Panel

**15 August 2008**

## 1. Introduction

CPMEC thanks the MTRP Secretariat for giving us this opportunity to make a written submission to the MTRP Review Process. We acknowledge the very significant contribution that MTRP has made in lifting the profile of prevocational training through initial funding to establish Postgraduate Medical Councils and subsequently providing grants for national projects aimed at improving postgraduate medical education and training. CPMEC has developed a close working relationship with the MTRP that has included being given the responsibility to draft national priorities to guide the selection of national MTRP projects in the prevocational domain. In addition, CPMEC has worked closely with the Clinical Training Subcommittee of the MTRP to gather data on clinical training arrangements in the prevocational years.

In relation to the issues identified in Chapter 16 of the MTRP Review Background and Issues Paper, we would like to make the following initial comments.

## 2. Is there a continuing role for MTRP? If so, what do you envisage that role to be?

CPMEC considers that MTRP's role when set up in 1996 to monitor the availability of training places remains germane in the current context of postgraduate medical education and training. The MTRP is well placed to monitor the changes in training capacity required to accommodate the increase needed. This would be a continuance of its previous role in monitoring trainee access to vocational training positions following the introduction of the Provider Number legislation in 1996.

MTRP's role can be considered from two perspectives. In the first instance, the MTRP has become an effective and unique forum to bring together a wide range of stakeholders in medical education and training on a regular basis. Whilst other Forums such as the MedEd Conferences provide some valuable information, MTRP has evolved into a core consultation forum. In future it could play a key **national** role in providing integrated and direct policy advice and debating key issues impacting on medical training and workforce issues. In this connection, MTRP should continue to work on the development of meaningful KPIs for medical education and training

In relation to the actual tasks undertaken by MTRP, a key contribution has been to facilitate improvement in data collection in relation to medical workforce. However, as noted in our Clinical Training Study report referred to earlier, there remain significant data gaps especially beyond the PGY1 year in prevocational training. This includes the situation regarding International Medical Graduates. MTRP's role should perhaps expand beyond mere collation to analyses of the data as well.

This monitoring and reporting function should cover all levels from undergraduate, through prevocational, vocational and specialist. The situation regarding career medical officers should also fall within the ambit of the MTRP as well as mmonitoring the provision of postgraduate training and accreditation processes for IMGs.

MTRP should also contract research studies and pilot projects of important national medical education projects. Priorities from a prevocational training perspective should be consistent with those identified in MTRP National Priorities Paper, the CPMEC report to MTRP on Clinical Training in Prevocational Years as well our submission to the National Health & Hospitals Reform Commission (the latter is attached).

We look to see continuing support for CPMEC and PMCs through support of activities that have a national focus. Ongoing support for the development and implementation of the Australian Curriculum Framework for Junior Doctors is a case in point. With impending national registration and accreditation, developing, evaluating and audit of national processes such as PGY1 allocation are other examples that will be critical for setting nationally consistent standards. Part of that support should also extend to identifying and supporting training innovation, particularly those which can be rolled out nationally. As part of its funding, MTRP should seek to build on projects that have had a good track record of implementation.

CPMEC is mindful that there are other Committees and organisations that play an important national coordinating role with regard to the training of the medical workforce. Under national registration and accreditation, with a national professional board, MTRP will be the best source of intelligent core data for the Health Workforce Principal Committee (HWPC) and the Australian Medical Council. We would also like to increase collaboration with other relevant taskforces and with universities. The Clinical training study was a useful start in this regard.

**3. How would it be different from current arrangements as you see it?**

A great deal of what has been suggested above would require a shift in emphasis and expansion of its current role rather than a radical departure. Nevertheless, some areas that need to be considered more systematically than may be case hitherto are:

- Workforce and training at all levels of the medical training continuum.
- Considering international trends and developments.
- Identifying new models of workforce and training to address increased medical graduate numbers.
- A greater focus on the indigenous health workforce.
- Interdisciplinary and role substitution considerations.

With regard to international developments, it might strategically be useful to consider how MTRP might separately, or in conjunction with events such as the MedEd conferences, share medical education, training and workforce experiences and issues with NZ, UK, Europe, North America and Asia. There have been significant changes occurring in the UK from which we can learn.

**4. Comments on current membership and administrative arrangements of the MTRP.**

It would be highly desirable for there to be a body that dealt with the continuum of medical training and encouraged all levels of government to work together. There are probably a number of ways to try to achieve this - via the MTRP, the AMC, or the

HWPC. However, it is unlikely to be as effective as MTRP where there is good representation of those working in the field and of trainees themselves.

Current membership is large and potentially unwieldy but broadly representative with the exception of indigenous and community representation. There could also be case for some consumer representation. If the current membership is to be retained there may be a case for additional State PMCs representation included in the membership to provide some operational perspectives in relation to prevocational training. Another option would be to have a smaller MTRP but retain the broad representation base.

One PMC has expressed concern that there is insufficient access to timely and detailed information about the MTRP's work. All minutes, reports and other publications should be published on the internet. A quarterly newsletter or information bulletin updating stakeholders and inviting feedback on the work of the MTRP would be useful in addition to the information provided to government and its principal committees.

**Attachment 1**

## *Summary of Recommendations*

***Recommendation 1:*** **There should be explicit funding and accountability for all stages of training to end the 'blame game,' prevent cost shifting and protect the training continuum, including:**

- **Explicit funding for health service based training for: educational supervision and support, teaching facilities, clinical skills laboratories and professional development programs. This should include adequate funding of PMCs**
- **Clearly identified funding for medical schools which covers the costs of teaching**

***Recommendation 2*****: All pre-vocational training positions should be accredited and PMCs should be accredited by the Australian Medical Council**

***Recommendation 3:*** **NHHRC should develop performance indicators that ensure that all groups involved in education and training are accountable**

***Recommendation 4:*** **Expansion of pre-vocational training posts should be targeted to:**

- **areas of workforce shortage in rural, regional and outer metropolitan Australia.**
- **disciplines with workforce shortages**
- **provide exposure to ambulatory medicine and the private hospital system**
- **achieve ACFJD learning objectives and provide protected training time**
- **manage the risk of unsafe working hours**
- **provide research funding to the development of new training methods, modification of existing methods, evaluating the effectiveness of training, and evaluating assessment methods and effectiveness.**

***Recommendation 5.*** **Ongoing development and implementation of the ACFJD should be funded.**

***Recommendation 6.*** **Performance indicators should be linked to workforce planning objectives.**

***Recommendation 7.*** **Clinical teachers should be recognised and rewarded by: realistic remuneration; inclusion of teaching in contracts and performance appraisals; access to professional development training; academic titles and administrative support.**

***Recommendation 8.*** **Australia should develop a coordinated network of clinical skills laboratories in clinical sites for use by trainees in all clinical disciplines**

***Recommendation 9.*** **Resources for IMGs should be significantly expanded to provide a well supported recruitment pathway, appropriate cognitive and clinical assessment at the time of recruitment, and educational resources to remedy any deficiencies identified**

***Recommendation 10.*** **CMOs should be provided with structured education programs**

***Recommendation 11.*** **NHHRC' performance indicators should include measures to improve and maintain the health and welfare of health professionals.**