

More students and less patients: the squeeze on medical teaching resources

We urgently need to expand clinical teaching into the private sector

In clinical school common rooms around the country, a common refrain of frustrated medical students is “*There aren’t any patients in the wards we can see!*” In this issue of the Journal, Olson and colleagues (page 461) report an investigation of hospital inpatients’ accessibility to medical students that strongly suggests that our students’ complaints are real.¹

The study simulated the experience of students attempting to see patients without the assistance of junior or senior medical staff. Four University of Newcastle medical students audited the wards of four public hospitals on three separate days, each 2 months apart. Inpatients were classified as present, present but not accessible, unfit to be seen on clinical grounds, or absent. Those who were present and accessible were asked if they would agree to a student taking a history and performing a physical examination.

Of 1960 patients, 959 (49%) were present and accessible and, of these, 673 (70%) said they would allow a student to take a history and 645 (67%) would allow a student to perform a physical examination. Half of all patients not available to be seen were

classified as unsuitable on clinical grounds, either by nursing staff or by the students. In some wards the students were told by nursing staff that all patients were unsuitable. In short, just over a third of the inpatients in these four hospitals were accessible to medical students.¹

Those responsible for clinical teaching programs in public hospitals are only too aware of this problem, which is caused by several factors. Reduced length of stay and “hospital in the home” programs designed to avoid or shorten admissions mean that inpatients are sicker and less inclined to see students. Moreover, as the average age of inpatients rises, an increasing proportion of inpatients are unable to give a history because of confusion or cognitive impairment. Another factor is that most elective surgical patients are now admitted on the day of their operation, leaving little time for students to make contact, and many are discharged the same day. In addition, some routine elective surgical procedures that students need to learn about are now very rarely performed in public hospitals. Finally, privatisation of hospital outpatient clinics has significantly reduced students’ exposure to ambulatory care.

Thus, there is increasing competition for scarce “clinical material”. Medical students must also compete with early postgraduate and vocational trainees, especially before postgraduate exams, and with overseas-trained doctors preparing for the Australian Medical Council exam.

The recent expansion of medical school places provides a major challenge for clinical educators.² Australia urgently needs more medical graduates to deal with patently obvious workforce shortages, but there are not enough suitable public hospital inpatients for the clinical teaching programs of the new medical schools, or for their graduates to complete postgraduate training programs. The apparent lack of planning in decisions about the new medical

schools will almost certainly exacerbate the problem identified by Olson and colleagues.¹ It is difficult to see how the clinical resources in New South Wales will be adequate for the projected increase in student numbers; yet, in Victoria, there has been virtually no increase despite a need for more graduates and capacity to train them. This might have been avoided if the recent spate of medical school expansion had been based on consultation with educators rather than driven by political considerations.

Are there any solutions? Olson and colleagues recommend better integration of students into clinical teams. This is sensible, but the magnitude of the problem demands more fundamental changes. The most obvious is to provide exposure to patients in other settings: general practice, specialists’ private rooms, privatised clinics and private hospitals. Many of the patients who used to

... there are not enough suitable public hospital inpatients for the clinical teaching programs of the new medical schools

be available for teaching in ambulatory settings in public hospitals have been diverted to these sites by state government cost-shifting. The Practice Incentives Program (PIP) has been an effective incentive for general practitioners to take on an enhanced role in

clinical teaching, but very few students have access to patients seen in specialists’ rooms or privatised outpatient clinics, where there are significant financial disincentives to teaching.³ We urgently need to explore ways of delivering and funding clinical teaching in these locations. Pilot programs that address the financial disincentives would be an excellent place to start, but would require a level of collaboration between federal and state governments, hospitals and universities that has been conspicuously absent in the decisions on new medical school places. Private hospitals are major beneficiaries of the Australian medical education system yet most contribute little to the training of their medical staff. A few have made arrangements to accept students, but there is clearly capacity to provide clinical teaching for many more.⁴ Australian taxpayers provide large sums of money to support the private health system. We should insist that some of this money is allocated to training its future workforce.

Another potential solution is to expand the use of simulation-based clinical teaching.⁵ Simulation-based teaching is no substitute for direct contact with patients, but it is an effective way to impart some clinical skills and may have some advantages; it can be delivered at the appropriate stage of the curriculum, students have more opportunity to practise in a non-threatening environment, and it is safer, particularly for procedural skills. Australian medical schools make extensive use of clinical skills laboratories in the early years of training, but our hospitals have been slow to acquire these facilities and have often developed them for nursing staff or postgraduate medical trainees rather than for the resource-deprived medical students. The high fidelity simulation centres, which have been developed in capital cities, are not accessible or affordable for day-to-day medical student teaching. Hospital-based clinical skills laboratories are expensive to build and equip and

require substantial funding for recurrent costs: teaching staff, surrogate patients, equipment and disposables. International experience suggests that they can help to compensate for declining numbers of accessible inpatients, but this won't occur without adequate funding or systematic planning by hospitals, universities and both levels of government.⁵

Australia has begun a long overdue, but poorly planned, expansion of medical schools. Olson and colleagues' report suggests that we are already struggling to provide clinical teaching for our current students in public hospitals.¹ If tomorrow's doctors are to graduate with adequate clinical skills, we urgently need to expand clinical teaching into other sites — specialists' private rooms, privatised clinics and private hospitals — and to develop multidisciplinary clinical skills laboratories in all training hospitals.

Brendan J Crotty

Clinical Dean, Austin Health / Northern Health Clinical School
University of Melbourne, Melbourne, VIC
b.crotty@unimelb.edu.au

- 1 Olson LG, Hill SR, Newby DC. Barriers to student access to patients in a group of teaching hospitals. *Med J Aust* 2005; 183: 461-463.
- 2 Lawson KL, Chew M, Van Der Weyden MB. The new Australian medical schools: daring to be different. *Med J Aust* 2004; 181: 662-665.
- 3 Health Insurance Commission. Practice Incentives Program. Available at: http://www.hic.gov.au/providers/incentives_allowances/pip.htm (accessed Sep 2005).
- 4 Griffith and Allamanda forge new medical partnership. Griffith University News, 2004; 10 Feb. Available at: http://www.griffith.edu.au/text/er/news/2004_1/04feb10.html (accessed Oct 2005).
- 5 Postgraduate Medical Council of Victoria. Clinical skills requirements of the health professions in Victoria. Melbourne: Postgraduate Medical Council of Victoria, 2003. □

Asthma in Australia 2005

A recent report outlines the good and the bad news about asthma

Asthma is a common chronic condition among Australians, particularly children. In recent years, federal and state governments have responded to community and health professionals' concerns by investing in strategies to improve asthma management.¹ Coinciding with this, new pharmaceutical formulations have become available for managing asthma. The latest publication from the Australian Centre for Asthma Monitoring and the Australian Institute of Health and Welfare, *Asthma in Australia 2005*,² provides a timely review of the good and the bad news about asthma over the past few years (Box).

The prevalence of asthma is high in Australia compared with other countries,³ affecting 14%–16% of children and 10%–12% of adults. However, *Asthma in Australia 2005* shows that, after a substantial rise in the number of children with asthma during the 1980s and early 1990s, this trend has reached a plateau. Although this pattern is consistent with observations in other countries, including Hong Kong, Switzerland and the United Kingdom,⁴ the reasons for this rise and subsequent plateau remain unknown. Nevertheless, the observation highlights the value of ongoing surveillance for asthma.

Over the past 5–10 years, rates of general practitioner visits and hospitalisations for asthma have declined substantially. Furthermore, deaths due to asthma have fallen by more than 50% since the early 1990s.

Despite these overall gains, there are important inequalities in the outcomes of asthma among Australians. Aboriginal and Torres Strait Islander people, particularly adults, have more asthma and higher rates of hospitalisation for asthma than other Australians. Adults living in rural or remote areas and people living in the most socioeconomically disadvantaged localities also have higher rates of hospitalisation for asthma. The reasons for these inequalities need exploring.

The burden of GP consultations, emergency department visits and hospitalisations for asthma is highest among children and probably reflects their higher rate of disease exacerbations. At the beginning of school terms, particularly in February, rates of emergency department attendance for asthma are higher than usual and the episodes are more severe than usual among pre- and

primary-school-age children. A similar return-to-school increase has been observed in other countries, and has been attributed to increased transmission of respiratory infections.⁵ This observation highlights the need to develop and test interventions to prevent exacerbations.

Regular use of inhaled corticosteroids can reduce asthma symptoms and prevent severe episodes of worsening asthma.^{6,7} However, *Asthma in Australia 2005* highlights evidence that inhaled corticosteroid therapy, the cornerstone of drug therapy for asthma, is not well targeted. Many people who would benefit from using

Major findings of the *Asthma in Australia 2005* report

Gains

The rising trend in the prevalence of asthma among children during the 1980s and early 1990s has reached a plateau. Currently, 14%–16% of children and 10%–12% of adults have asthma.

In 1990, there were 822 deaths attributed to asthma in Australia (5.6 per 100 000), whereas in 2003 there were 314 deaths (1.5 per 100 000).

Hospitalisation rates for asthma have declined from 920 patient-days per 100 000 in 1993–94 to 419 patient-days per 100 000 in 2003–04.

No gains

Hospitalisation rates for asthma in 2002–03 were higher among:

- Aboriginal and Torres Strait Islander people compared with others in Australia (1003 v 418 patient-days per 100 000);
- Adults in rural and remote areas compared with adults in major cities and regional areas (728 v 331 patient-days per 100 000); and
- People with greater levels of socioeconomic disadvantage (528 patient-days per 100 000 in the most disadvantaged quintile v 309 patient-days per 100 000 in the most advantaged quintile).

Only 34% of people with asthma aged 15 years and over are using inhaled corticosteroids, but 71% of inhaled corticosteroids are supplied in the highest dose formulations.

In South Australia, the proportion of people with asthma who stated that they owned a written asthma action plan declined from 42% in 1995 to 22% in 2001. ◆