

Medical education in Australia: changes are needed

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It is time for less talk and more action

In Australia each year, close to 1600 medical graduates set off on the long and lonely road of prevocational and vocational education and training.

To a casual observer, this journey might seem a simple matter, but two articles in this issue of the Journal^{1,2} refute this. Systemic shortcomings that these authors and others³ raise include a lack of coordination in the provision of education and training to junior doctors and a lack of integration of undergraduate prevocational and vocational training programs. For possible solutions, both McGrath et al¹ (page 346) and Paltridge² (page 349) look overseas to Canada and the United Kingdom.

In Canada, the university medical schools are responsible for training medical specialists. There are strong links between medical schools and training hospitals, and a major commitment by hospitals to education and training. As well, senior clinical staff are committed and appropriately well paid to teach. Furthermore, medical students in Canada must decide before or at graduation which specialty they wish to enter — there is no internship.

The different but comprehensive UK program is of two years' duration, and "shifts medical education away from the apprentice-style of training to working and learning in teams."⁴ Postgraduate deans, attached to each National Health Service Trust, fund and manage postgraduate programs across all specialties, and a new statutory body, the Postgraduate Medical Education and Training Board, will oversee all programs.

Neither of these programs would sit comfortably in Australia. Our medical school graduates lack the skills and experience to enter directly into specialist training; medical schools lack the resources to oversee all postgraduate programs; and the current thrust in Australian medical education is to attempt to shorten the overall training period. Currently, accreditation and registration focus on process rather than outcomes, and a more flexible approach to linking progress to competencies rather than time spent in training is being considered.⁵

What both the Canadian and UK systems have that we do not is appropriate funding of undergraduate teaching. We also lack adequate numbers of medical students, recognition that good clinical teaching is as important as research or clinical practice, delineation of our overall medical workforce needs, medical student intakes that reflect projected workforce needs and the training to meet these needs and, finally, an appropriately coordinated and integrated system of undergraduate and prevocational and vocational medical education and training.

Let us examine these issues in greater detail, beginning with the issue of appropriate funding of undergraduate teaching.

Reduced federal government funding in recent years for undergraduate teaching supported by the Higher Education Contribution Scheme (HECS) has meant an increased intake of full-fee-paying overseas and also local students. The February 2006 meeting of the Council of Australian Governments (COAG) announced an increase in Australian full-fee-paying students from 10% to 25%, and a further increase of HECS places through to 2008.⁶

The fees generated by these full-fee-paying students will assist medical schools, but the tensions with clinical teachers who are required to teach overseas students, and who gain no recompense for this training, will remain even though pragmatic changes to the immigration act are allowing overseas students to remain in Australia. It should be noted that university administrations retain some 40% of medical student fees for "general revenue". Medical schools should not be fundraisers for the whole university.

Secondly, clinical teaching requires appropriate recognition. Most medical practitioners are willing to teach junior colleagues, but are hindered by time and money. Time needs to be set aside within teaching hospitals for teaching postgraduate students; a prerequisite for appointment to the staff of teaching hospitals should be a willing commitment to teach; and teaching time should be appropriately funded. Further, all hospital administrators and health bureaucrats must recognise the dual role of teaching and clinical service within teaching hospitals. The days of pro-bono teaching are long gone, and there must be budgeting for clinical training.^{5,7}

Thirdly, overall workforce needs need to be delineated. Workforce planning is not a precise science and has many inherent difficulties, as shown in the Productivity Commission's 2005 health workforce report.⁸ This report recommends establishing a single workforce secretariat to replace both the Australian Health Workforce Advisory Committee and the Australian Medical Workforce Advisory Committee, which would report directly to the Australian Health Ministers' Advisory Committee.

In making this recommendation, the Productivity Commission accepted the advice of many submissions, and stated that workforce projections undertaken by the secretariat should be directed at advising government that meeting different levels of health service demands requires equal consideration of the need for training and education of health care workers. Simply put, service demands require similar demands in education and training.

Fourthly, both intakes and training of medical students need to meet projected workforce needs. The major problem in planning medical student numbers is the 8–10-year lag between entering medical school and unsupervised medical practice. The reduction in medical school intakes in the early 1900s led to a shortage of medical practitioners and the need to recruit overseas-trained doctors. This recruitment has not been without difficulties.¹

The pendulum is now swinging in the opposite direction, with a recent increase in HECS places, the decision to allow overseas students to remain in Australia and enter specialist training, the creation of new medical schools, and the very recent COAG decision to increase the number of local fee-paying students and increase the number of HECS places through to 2008.

These decisions will increase student numbers, but it is not clear how, where, and by whom they and future postgraduate trainees will be trained. This important issue is well recognised. Olson and colleagues, writing in this Journal, point out that medical students cannot acquire appropriate clinical experience because of the unavailability of patients in teaching hospitals.⁹ They state, "... it is

clear we must find alternatives to teaching hospitals for acquiring clinical skills.”⁹ Crotty takes the matter further, pointing out the multiple factors that reduce the value of the so-called teaching hospitals for student training, and the lack of consultation in developing new medical schools.¹⁰ He advocates teaching in private hospitals and private clinics, simulation-based clinical teaching, and increasing teaching in general practice and the community. This would require adequate funding, and agreements forged between universities, public and private hospitals and federal, state and territory governments.

Finally, we come to the issue of needing a coordinated, integrated, and accredited system of undergraduate, prevocational and vocational medical education and training. McGrath et al¹ and, to a lesser extent, Paltridge,² lament our current lack of coordination and planning.

While there is some ad-hoc integration of education, by and large, the various “units” involved in education act separately. There are at least 10 different agencies involved in postgraduate training. This modern Tower of Babel includes: the Australian Government Department of Education, Science and Training and Department of Health and Ageing; state and territory governments and health departments; teaching hospitals and training units; specialist colleges; Committee of Presidents of Medical Colleges; Confederation of Postgraduate Medical Education Councils; university medical schools; Australian Medical Council (AMC); state prevocational medical councils; and the Medical Training Review Panel. Overlying each of these are the special requirements for assessing standards for overseas-trained doctors.

In an article on this subject, Dowton et al concluded by saying, “It is time to comprehensively review the oversight and governance of postgraduate medical education and training.”³ There have been numerous national workshops, national conferences, and review articles suggesting the way forward, but little has been achieved.

A recent conference hosted by the Committee of Deans of Australian Medical Schools and the AMC recommended that registration, accreditation and clinical progress be linked to competencies rather than time spent in training.⁵ The conference also recommended the establishment of a National Healthcare Education Council, which should be independent, funded by and reporting to the Australian Health Ministers’ Conference (AHMC), and should include all stakeholders. The Productivity Commission also recommends a body along these lines — the Advisory Health Workforce Education and Training Council — to provide the AHMC with independent and transparent assessments of health care workforce and education and training needs, and of the implications of courses, curricula and accreditation. The importance of combining assessments of workforce (ie, service delivery) needs with education and training cannot be overestimated, and cooperation between the federal health department and DEST is essential. The overall solution also requires changes at state and territory levels.

New South Wales has long been a leader in postgraduate medical education, with the formation of the Postgraduate Medical Council of NSW (PMCNSW) in 1988. The recent establishment of the Institute of Medical Education and Training,¹¹ combining the roles of PMCNSW and the Medical Training and Education Council, is a major step forward. The new Institute has a broad brief to:

- provide high quality and appropriate medical education and training for trainees, supporting quality and safe care and services to patients;
- provide support to area health services and other public health organisations that control public hospitals in relation to postgraduate medical education and training;
- develop systems and processes to enable the distribution of medical training positions within area health services and other public health organisations that control public hospitals in a manner aligned with their service and training and education; and
- develop postgraduate medical training networks and other training support infrastructures for area health services and other public health organisations that control public hospitals.

The Institute has broad professional representation and reports through its advisory board directly to the NSW Minister for Health.

Each state and territory needs to establish such an independent body reporting directly to the Minister for Health, and so create order and coordination in the medical workforce and in education and training. This will require political will and less talk and more action. It is time.

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- 11 NSW Institute of Medical Education and Training [website]. Available at: <http://www.mtec.nsw.gov.au> (accessed Mar 2006). □