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AMA

The AMA Council of Doctors in Training (AMACDT) is a national AMA Group that represents junior doctors through a hospital and State-based representative structure. The AMACDT held its most recent quarterly meeting in Melbourne on 29 & 30 July 2006.

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Trainee representation

The AMACDT played a key role on the AMC working group on College support for trainees and put forward a number of points from its policy that trainees should be effectively consulted and represented on College boards and committees. Many of these points were taken up in the working group's report, which is now being considered by a larger AMC committee reviewing accreditation criteria for vocational training programs.

AMA President tackles COAG on clinical training

In February, the Council of Australian Governments (COAG) meeting announced an increase in the cap on domestic full fee paying medical school places from 10% to 25% of enrolments. On 8 April the Prime Minister announced a further increase of 400 HECS funded medical school places and by the time the July meeting of COAG came around the Government committed itself to a further increase of 205 HECS funded places.

Taking into account various announcements made over the last few years, by 2012 Australia will have in excess of 3200 first year medical places for domestic students. This compares to 1300 in the year 2000.

AMA President, Dr Mukesh Haikerwal, has been campaigning vigorously for more resources, supervision and infrastructure to support these increases. In the lead up to COAG the AMA publicly warned of an impending crisis in medical training unless the Commonwealth and the States worked together to address this issue.

The COAG Communiqué released on 14 July partially acknowledged the AMA's concern, with State/Territory leaders giving a guarantee that they would ensure sufficient clinical placements and intern jobs for all future HECS funded medical students. This guarantee, however, does not extend to domestic full fee paying students and no commitment on specialist training positions was provided.

The AMA has called on State/Territory leaders to work with the AMA to develop clear plans to address this critical issue and has made it clear to the Commonwealth that it needs to hold State/Territory Governments to account in meeting the commitments given at COAG.

To read a full transcript of Dr Haikerwal's recent media comments on medical school places, please visit:

<http://www.ama.com.au/web.nsf/doc/WEEN-6RD8MM>

Student survey highlights AMA concerns

A recent survey of 561 medical students in Western Australia looked at student views on increased medical school numbers. WA has experienced a dramatic increase in student numbers.

The survey report* found that 80% believed increased numbers would have a negative impact on the quality of their education while 77% were concerned about the quality and availability of future training positions.

Strong themes that emerged from the survey were the dissatisfaction with the high rates of student to teacher ratios and the increasing reliance on junior doctors as teachers instead of more experienced clinicians.

* *The Changing Medical Workforce in Western Australia: Student Perceptions* - Ruth E Blackburn, Hospital Medical Officer; Ian R Rogers, Director, Postgraduate Medical Education; Ian G Jacobs, Associate Professor of Emergency Medicine; Sir Charles Gairdner Hospital, Perth, WA.

Council of Australian Governments Meeting

Beyond new medical school places, the COAG meeting held on 14 July 2006 made a range of decisions on health workforce. Many of these were outlined as a response to the recommendations contained in the Productivity Commission's Report on Health Workforce.

The key COAG recommendations covered:

- A Memorandum Of Understanding between the States and the Commonwealth outlining commitments to greater consultation over future health related University places
- The establishment of a Taskforce on national health workforce, which will undertake project based work and advise on workforce innovation and reform
- Introduction of a new Medicare item to support practice nurses, nurse practitioners and registered aboriginal health workers, for and on behalf of General Practitioners, to provide ongoing support for patients with a chronic disease
- A single national registration scheme covering health professionals
- A national accreditation scheme for health education and training
- A commitment to further expand the unfunded bonded medical school places scheme, although no details were attached to this
- A commitment to expand specialist training into an expanded range of clinical settings beyond traditional teaching hospitals to include a broader range of public settings and the private sector
- Recognition of rural medicine as a generalist medical discipline, subject to the decision of the Australian Medical Council
- A commitment to develop options for improving the delivery of rural/remote health services by the end of 2006
- A commitment to the introduction of nationally consistent processes and standards governing the assessment of overseas trained doctors by the end of 2006

The AMA was particularly pleased to see that COAG committed to allowing specialist trainees to access a broader range of clinical settings, including the private sector. The AMACDT has been heavily lobbying for this during recent years and welcomes the commitment to introduce appropriate arrangements by January 2008.

Common sense also prevailed with the decision to resist pressures to open up the CMBS to other health professionals. The extension of "for and on behalf of" item numbers is a far more sensible direction that follows a team-based approach to care – coordinated by a GP.

The AMA remains opposed to the introduction of a national health workforce registration framework and the national accreditation of health workforce education and training. This inevitably dilutes the influence of the medical profession and, taken together, establishes a framework that supports the introduction of new "technician" type roles and supporting training courses that give greater scope for the substitution of doctors.

Unfortunately, the Government appears committed to a further expansion of the unfunded bonding arrangements for medical students. This comes in spite of overseas evidence showing that bonding is ineffective. The AMA has put forward an alternative plan to the Government that is incentive based and which is designed to encourage doctors to take up rural practice as a long-term career option.

For more information on the AMA response to the COAG Communiqué, please visit:

<http://www.ama.com.au/web.nsf/doc/WEEN-6RPBBM>

Safe Hours Audit

The AMA's national on-line audit of doctors' working hours has now closed, with detailed data collected from more than 700 doctors for the period 8 to 14 May 2006. Individual doctors could get an immediate assessment of the risk level posed by their hours and patterns of work.

Anyone with concerns about their roster should contact their State/Territory AMA, who are well placed to take up issues raised by members whose work hours present a safety risk. The audit data is being checked and processed, with a report on the outcome to be released later this year.

Leadership Development Session

The 2006 AMA Leadership Development Session, run alongside the 2006 AMA National Conference, was a great success with positive feedback from AMACDT members and participants alike. Strong support has been expressed for a similar event during next year's AMA National Conference in Melbourne.

The final list of speakers was Dr Bill Griggs (South Australian of the Year), Mr John Hill (SA Health Minister), Dr Mukesh Haikerwal, Dr Bill Glasson, Margaret Lyons (Dept Health and Ageing), Jim Birch (CEO SA Health Dept), John Flannery and Laurie Wilson.

The AMA is particularly grateful to UMP, who sponsored the Leadership Development Session.



Debt and doubt for full fee students

As year 12 students around the nation prepare to apply to university and chase their dreams of becoming doctors the AMA has warned that some may be saddled with enormous debt and left holding degrees with questionable value.

The AMA has highlighted that full fee-paying medical student places are on offer at public and private universities and it's possible that once these students graduate there will be no clinical training available for them.

The recent COAG meeting recognised the AMA's call to ensure that medical students have access to adequate clinical training, with the States and Territories promising to fund clinical placements and intern jobs for all Commonwealth-funded students.

But COAG excluded full fee-paying students from this policy, potentially leaving up to 20 per cent of future medical students uncertain about whether they will have a career in medicine.

The AMA has delivered a blunt message to the Government. It must either abandon its commitment to full fee-paying places, or ensure the States and Territories fund clinical places and intern jobs for all medical students.

GP Training

The Government has relaxed the provisions of the rural pathway in the general practice training program. The AMACDT has been heavily involved in lobbying to address the weaknesses of the rural pathway, which until now has been restricted to RRMA 4-7 placements.

The rural pathway has been criticised for being too rigid (eg: not allowing registrars to move when their has been change in personal circumstances), hampered by poorly targeted financial incentives, and for placing junior doctors in challenging environments where they find it difficult to access enough support and supervision.

The Government has decided to allow GP registrars on the rural pathway to spend part of their early training in a major rural centre, which is a step in the right direction.

This will give GP registrars access to more support while they find their feet and provide them with the confidence to move to more challenging environments when they have got more experience under their belt.

In the longer term, the AMACDT believes that it would be preferable to have the rural pathway abolished to encourage more junior doctors to try general practice, without the fear of being locked into rural areas. Coupled with proper incentives, more flexible GP training arrangements are likely to increase the number of doctors looking at a career in rural general practice.

AMA National Press Club Address

Dr Mukesh Haikerwal gave the annual AMA address to the National Press Club on 19 July 2006. The speech touched on a number of issues of importance to junior doctors including medical education and unfunded bonding. A full transcript of the speech is located at:

<http://www.ama.com.au/web.nsf/doc/WEEN-6RU76U>

AMA supports team based care policy

Federal Council passed an AMACDT sponsored policy paper on role substitution in the public hospital workforce - which emphasises a team based approach to care.

The AMA position statement - *Task Substitution in Public Hospital Settings* recognises the integral role that nurses and other allied health professionals play in the delivery of health care in hospital settings and that many are highly trained in specific fields - allowing them to work with limited supervision. It also acknowledges that over time the roles of doctors, nurses and other allied health professionals will evolve in response to the changes in the delivery of health care.

A key plank of the policy is that proposed changes to the roles performed by health professionals must not be introduced as a reaction to workforce shortages. Workforce shortages exist across most health professions and pillaging one group of health professionals to fill gaps elsewhere is counterproductive.

The AMA believes that workforce changes must be driven by quality and safety and enhance the efficiency of the health workforce. In this regard, the position statement outlines key criteria for future workforce change such as:

- Expanded roles must enhance patient outcomes;
- A medical practitioner must remain responsible for coordinating the health care team and managing the care of patients;
- Opportunities for medical students and doctors to learn and practise essential clinical skills must be maintained.

A full copy of the AMA position statement *Task Substitution in Hospital Settings* is on the web at:

<http://www.ama.com.au/web.nsf/doc/WEEN-6QAVPF>

CPMEC gets it wrong on consultation with junior doctors

The Confederation of Postgraduate Medical Education Councils (CPMEC) has embarked on a project to develop a new national curriculum framework for prevocational doctors – “*The Australian Curriculum Framework for Junior Doctors*”.

The AMA Council of Doctors in Training (AMACDT) has often been suspicious of attempts to review the curriculum for the PGY1 & 2 years. Some groups have tried to use past reviews to push an agenda to introduce more prescriptive assessment methods for junior doctors. The last thing PGY1& 2 doctors need is another medical school style exam or tick a box assessment tools.

Despite these reservations, the AMACDT has actively sought involvement in this project. If a national curriculum is to come to fruition, the AMACDT believes it should play a constructive role in making sure that the curriculum properly covers the skills junior doctors need and assists in their professional development.

Instead of welcoming valuable junior doctor input the AMACDT was initially greeted with deafening silence. Following this AMA Federal Council intervened and demanded some answers from the CPMEC. Dr Haikerwal's subsequent letter had CPMEC representatives quickly trying to justify their consultation process and meetings with the AMACDT Chair and the AMACDT were hurriedly organised.

The Chair of CPMEC, Professor Barry McGrath, has now openly acknowledged the important role played by the AMACDT and has committed to further consultation. However, doubt remains amongst AMACDT members about just how much genuine involvement the CPMEC will allow junior doctors to have.

The CPMEC has established a very tightly controlled consultation process, which could limit meaningful input from groups like the AMACDT. Governments and health sector organisations readily seek input from junior doctors by appointing AMACDT representatives to key committees and writing groups. The CPMEC needs to catch up with the times.

The bottom line is that the AMACDT should be involved in the committee that is developing *The Australian Curriculum Framework for Junior Doctors* and, just as importantly, the AMACDT should be part of the implementation process.

The challenge the CPMEC now faces is whether it wishes to genuinely involve the AMACDT, or simply be seen as having involved only those groups handpicked by the CPMEC.

More information is available from <http://www.cpmec.org.au/curriculum/index.cfm>

Employment of Medical Students in Hospitals

Following reports that some final year medical students had been employed inappropriately to fill medical workforce shortages, the AMACDT and other AMA committees had a close look at this issue.

The AMA believes that medical students are not substitutes for any type of Medical Officer and they should not be utilised to fill gaps in the medical workforce. The role of medical students in hospitals and other clinical settings should be focussed on learning rather than fulfilment of employment obligations and tasks. Federal Council approved an AMA position statement *Employment of Medical Students in Hospitals* in May 2006. A full copy of the position statement is available on the web at:

<http://www.ama.com.au/web.nsf/doc/WEEN-6QAVEC>

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The AMACDT is established as a Committee of the Federal Council of the AMA and reports directly to Federal Council on issues of importance to junior doctors.

Junior doctors who want to contact their State/Territory AMACDT representative can do so via the above contact details.