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The AMA's National Doctors-in-Training Publication

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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 Canberra on 7 & 8 October 2006.

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AMA Safe Hours Audit 2006 – Junior doctors

AMA President, Dr Mukesh Haikerwal, has called on State and Territory Governments and public hospital administrators to urgently review rostering and work practices for hospital doctors after an AMA survey revealed that almost two-thirds of public hospital doctors are working unsafe hours.

The AMA Safe Hours Audit 2006 has found that 62 per cent of Australian hospital doctors are working unsafe hours – classified as high risk or significant risk – with one doctor reporting a continuous unbroken shift of 39 hours.

The survey is the first of its kind in Australia for five years and follows the groundbreaking AMA Safe Hours Audit 2001.

Dr Haikerwal said the 2006 survey exposes work practices that contribute to doctor fatigue and stress levels that ultimately impact on the quality of care and patient safety in the public hospital system.

"All Australian governments must take a close look at the results of this survey and urgently put in place measures to dramatically improve the work conditions and work practices for doctors," Dr Haikerwal said.

Conducted in May 2006, the audit tabulated responses from more than 550 public hospital doctors of all ages from all States and Territories.

The on-line survey collected data on the hours of work, on-call hours, non-work hours, and sleep time experienced by doctors working in the public hospital system over a full working week.

The most stressed discipline is surgery, where 85 per cent of doctors fall into the significant risk and higher risk categories.

There are minor improvements over the AMA's 2001 survey results, where 78 per cent of respondents fell into the significant risk and higher risk categories.

Some other indicators show signs of improvement. For example, for doctors in the higher risk category the longest continuous period of work fell from 63 hours to 39 hours.

Doctors had more full days off work during the audit week and more opportunities for meal breaks when working.

But in the AMA's view, shifts of 39 hours are no more acceptable than 63-hour shifts.

The average of total hours worked in the 2006 audit week was the same as in 2001. However, the longest hours worked by individuals during the audit week actually went up - to 91 (from 86) and 113 (from 106) for the significant risk and higher risk categories respectively. This indicates that the riskiest work patterns are still commonplace.

Dr Haikerwal said that in any other industry or profession, these 'improved' figures would be cause for deep concern and immediate remedial action.

The AMA has written to all State and Territory Governments urging them to act on the findings of the AMA Safe Hours Audit 2006, which is available in full on the AMA website at http://www.ama.com.au/web.nsf/doc/WEEN-6UWAUH

Clinical handover guide to be launched

The AMA will soon launch ***Safe Handover**: Safe Patients. Guidance on Clinical Handover for Clinicians and Managers.* Developed jointly by the AMACDT and the AMA Coordinating Committee of Salaried Doctors, this Guide will be the first of its kind published in Australia.

The guide has been developed by the AMA to raise awareness of safe handover, which is crucial to improving patient safety. As doctors pursue safer/more flexible working arrangements, systems need to be put in place to ensure that patient safety is not compromised.

This guide will join a number of other resources developed by the AMA to support safe hours and work-life flexibility initiatives such as the AMA Best Practice Rostering: Training and Resource Kit and AMA Work Life Flexibility Guides. The clinical handover guide will be available in late January 2007 at:

www.ama.com.au/handover

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Medical education requirements need agreement

Dr Tanveer Ahmed, Chair of the AMA Council of Doctors-in-Training (AMACDT), has urged federal politicians to consider making medical clinical training issues a standard feature of future Australian Health Care Agreements.

Appearing before the House of Representatives Standing Committee on Health and Ageing, Dr Ahmed detailed the pressures increased medical school numbers will place on the training system.

His message was simple – the increase in training places required more tangible support than the political rhetoric currently on offer. Dr Ahmed emphasised that the Commonwealth's significant increases in student numbers was only the start of solving the workforce shortage problem.

"Greater steps are now needed to ensure all students receive proper training, including adequate clinical experience," he said.

"There is a lack of activity from some State and Territory Governments in ensuring their public hospitals can provide training for all new graduates," Dr Ahmed said.

"Solutions to this problem can be provided by expanding training into private clinical centres, which can complement and support public hospital training.

"But I am firmly of the opinion that Australian Health Care Agreements should include negotiations and arrangements covering the adequacy of training infrastructure and services.

"Formally locking the Federal Government's responsibility for tertiary education and the State Governments' responsibility for hospital training into Agreements is about the best guarantee we have for maintaining training levels for junior doctors and medical students," he said.

Dr Ahmed also used the opportunity to push the AMA's position urging the Government to reverse its recent decision to increase the number of full fee paying medical students.

He said the training sector needs 'breathing space' to build the resources capable of supporting increased medical student numbers.

"The AMA also believes the Australian Medical Council should review the ability of individual medical schools to provide adequate training, before the student number increases announced by the Government in July are implemented," Dr Ahmed said.

"And if more medical trainees are placed in rural locations, they must be backed by proper resources and supervision.

"If this is not done, the benefits of encouraging doctors into a rural setting to fill workforce gaps are lost."

The Health and Ageing Committee has now released its report, *The Blame Game: Report on the inquiry into health funding*, which picked up on the issues raised by the AMA and recommended more funding to support clinical training and the introduction of performance benchmarks to ensure that more clinical places are provided in the future.

Early streaming into specialty training

AMA Federal Council has backed the need for junior doctors to have a strong generalist experience before entering specialist training by adopting the AMACDT sponsored position statement on early streaming at its most recent meeting.

Amid intense debate about medical education and training and continuing concerns about a medical workforce shortage, there has emerged a push by some groups towards early streaming of medical students and graduates into specialty training.

The AMA position statement supports continued emphasis in the undergraduate and early postgraduate years on a well-rounded generalist orientation. This enables junior doctors to develop, through practical training and experience, the set of professional knowledge and skills which underpins their entire medical careers and readies them for the specialist vocational training offered by medical colleges. A full copy of the position statement can be viewed at:

http://www.ama.com.au/web.nsf/doc/WEEN-6WA6UH

AMA Comparison of Specialist Medical Colleges

The AMA's Comparison of Specialist Medical Colleges are amongst the most visited pages on the AMA website. They provide doctors who are choosing their vocational pathway with information on the training requirements, conditions and costs of Medical College training programs.

These pages have been recently updated and can be viewed at:

http://www.ama.com.au/web.nsf/doc/WEEN-6CY26T

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AMA tackles ACCC on trainee issues

The AMA has lodged a submission with the Australian Competition and Consumer Commission (ACCC) regarding ACCC proposals to alter the conditions of Authorisation for the Royal Australasian College of Surgeons (RACS).

In its submission the AMA targets the apparent refusal of the ACCC to accept that trainees are the ultimate consumers of College training programs and deserve to be afforded the same protection by the ACCC as it gives other groups.

The ACCC's inflammatory draft determination rejects the view that RACS should be able to ensure there is some balance between Basic Surgical Training (BST) and Specialist Surgical Training (SST) numbers – regardless of the fact that this may lead to training bottlenecks and could prevent many trainees from completing the surgical training program.

The AMA submission highlights that the College aims to produce fully-fledged surgeons – not BSTs or SSTs, while trainees rightfully expect that if they enter the surgical training program they should be able to achieve Fellowship provided they satisfy assessment requirements. The AMA submission states:

> *"Trainees enrol because they want to become a surgeon and are prepared to devote a significant part of their life to the achievement of this goal. The surgical training program also comes with a hefty price tag, with no change from $20,000 for completion of the BST program alone. The lack of regard the ACCC shows for this is disappointing, and fails to acknowledge that without some certainty over progression through the surgical training program – young doctors are likely to look to other specialties for a career."*

The AMA also rejects the view put forward by the ACCC that the attempts by RACS to align BST and SST numbers is not related to the quality of training and states that:

> *"Quality surgical training is not about producing half trained surgeons. The foundation of a high quality training program is the principle that trainees will ultimately be ready for unsupervised, independent practice – equipped to handle most situations that they will face in the management of their patients."*

The ACCC is involved in other processes affecting College training programs and although this submission essentially dealt with RACS, it was important not to leave unchallenged the views outlined by the ACCC. If this draft determination reflects the broader thinking and approach of the ACCC, then it devalues the role of Colleges in protecting standards and fails to recognise the legitimate interests of trainees.

DiT issues prominent in AMA Federal Budget Submission

The AMA has lodged its 2007/2008 Federal Budget Submission, which included a proposal to expand specialist training into private clinical settings and measures to beef up support for bonded medical school students. Full details of the submission can be found at:

http://www.ama.com.au/web.nsf/doc/WEEN-6VSVST

Rigid rules keeping potential GPs out of vital training program

AMA President, Dr Mukesh Haikerwal, has highlighted that only 160 of a possible 280 places had been filled in the important General Practice Pre-vocational Placements Program, which is designed to encourage more doctors to consider a career in general practice.

Dr Haikerwal said rigid rules are deterring doctors from joining the program, as many metropolitan practices are excluded. He said some State Health Departments won't allow their doctors to join and are using misplaced concerns over workers' compensation and indemnity as a smokescreen.

"When communities around the country are screaming out for new GPs, it is a crime that these placements are not being filled," Dr Haikerwal said.

"The Federal and State Governments must recognise that there is a shortage of GPs across the country and get together to open up the program.

"This is an excellent Program to get more doctors into general practice but our governments are not allowing it to meet its potential."

The General Practice Pre-vocational Placements Program was established in 2003 by the Federal Government, which funds up to 280 places each year. Each placement is for a period of up to three months.

While working in hospitals, junior doctors are normally given rotations in specialty areas such as emergency medicine, surgery, and medicine. Dr Haikerwal said "this has a big impact on what specialty these doctors choose for their career, so adding some GP experience at this stage is very important."

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Medical Education Study

The AMA has submitted a second submission to the Department of Education, Science and Training's Medical Education Study.

The Government has twice called for submissions to the Study, saying many key stakeholders failed to contribute the first time around. The Government expanded criteria for the second round of submissions, to include course content, selection of students and assessment.

The AMA submission highlights that selection methods should be supported by research to ensure they are fair, reliable and valid in predicting future performance as a student and doctor. Both AMA submissions can be viewed at:

http://www.ama.com.au/web.nsf/doc/WEEN-6MPU49

CPMEC recognises need for AMACDT involvement in new curriculum

The Confederation of Postgraduate Medical Education Councils (CPMEC) has recognised the importance of informed junior doctor input into the implementation of the Australian Curriculum Framework for Junior Doctors.

CPMEC Chair, Professor McGrath recently wrote to the AMA advising that the AMACDT will be invited to sit on a National Steering Group to oversee the implementation of the national Curriculum Framework. This is a welcome step forward by the CPMEC and junior doctors can now feel confident that they have a strong, independent voice in discussions over the implementation and evaluation of the national Curriculum Framework.

New Minimum Terms and Conditions for GP Registrars

The 2007 National Minimum Terms and Conditions for Basic and Advanced GP Terms has been finalised by General Practice Registrars Australia and the National GP Supervisors Association, with assistance from the AMA.

To obtain a copy, visit www.ama.com.au

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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.

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