

Confederation of Postgraduate Medical Education Councils



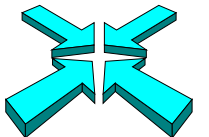
“An Overview of Key Issues & Challenges in Prevocational Training”

Professor Simon Willcock, Chair, CPMEC
2011 Prevocational Forum, Auckland NZ

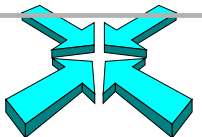
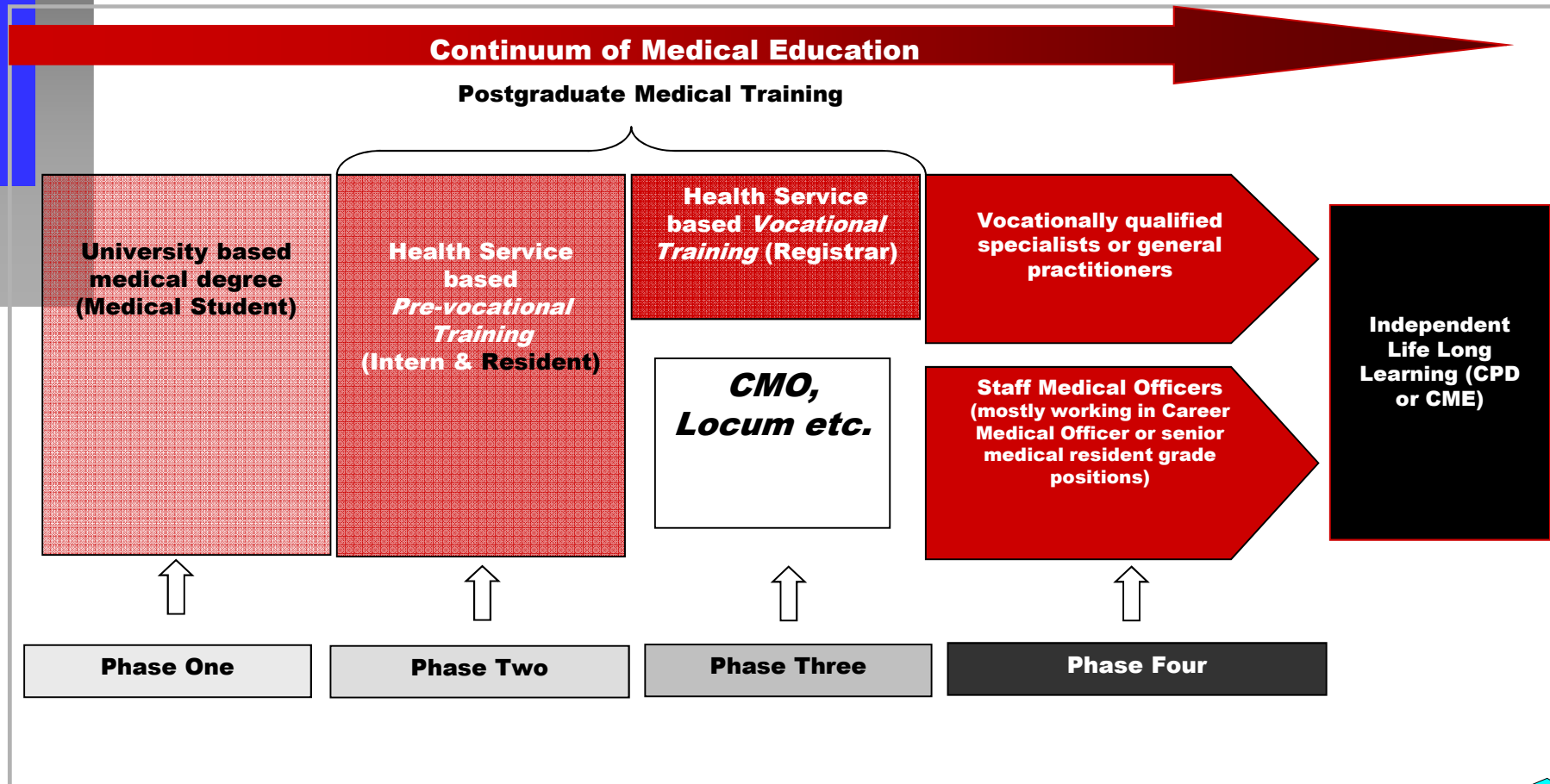
7 November 2011

Prevocational Education and Training

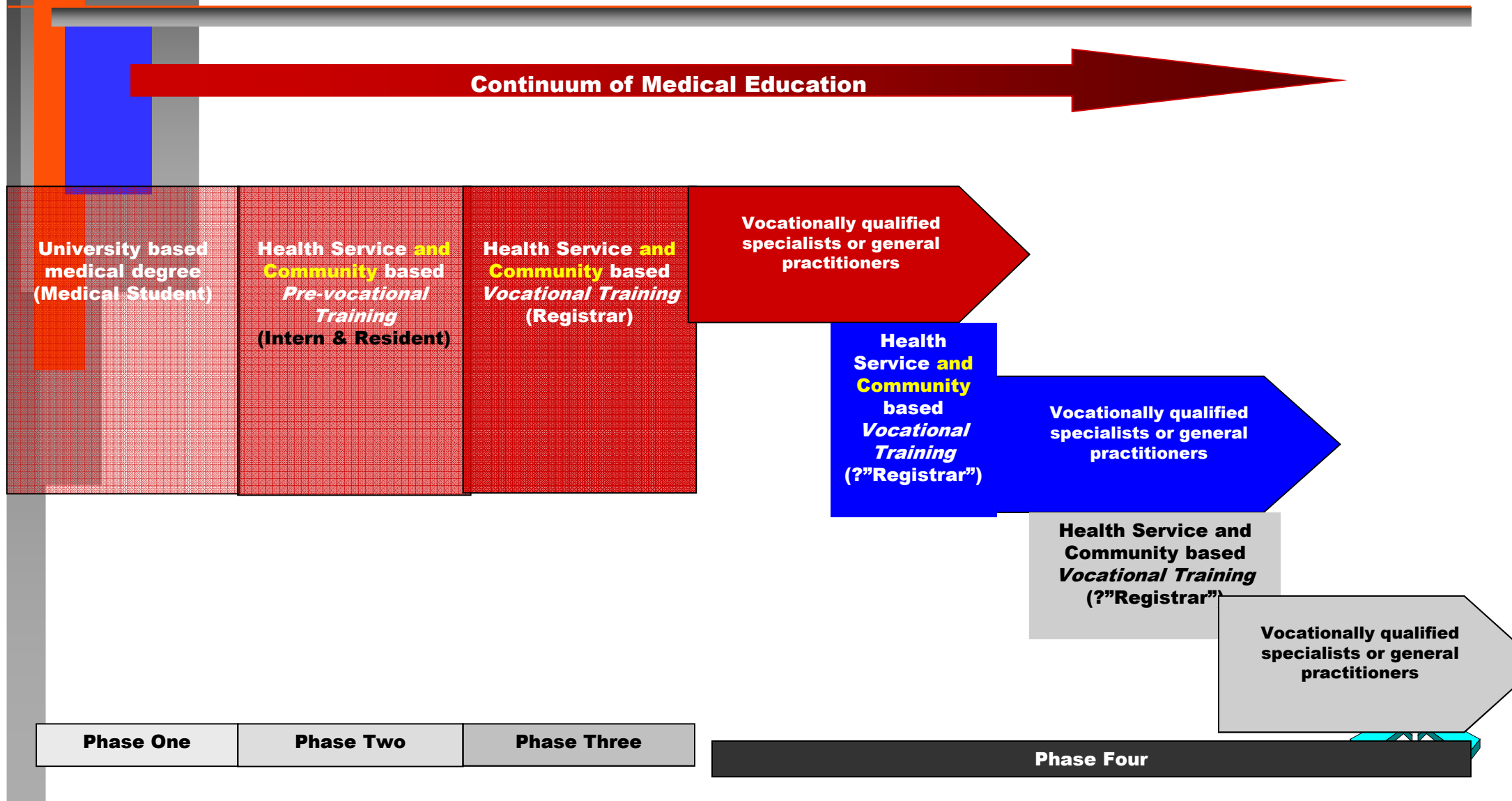
1. Do we really understand it?
2. Do we really need it?
3. What are the current issues in PVET?
 - general / specific
4. What are the factors that will influence PVET over the next decade?
5. What keeps me awake at night?



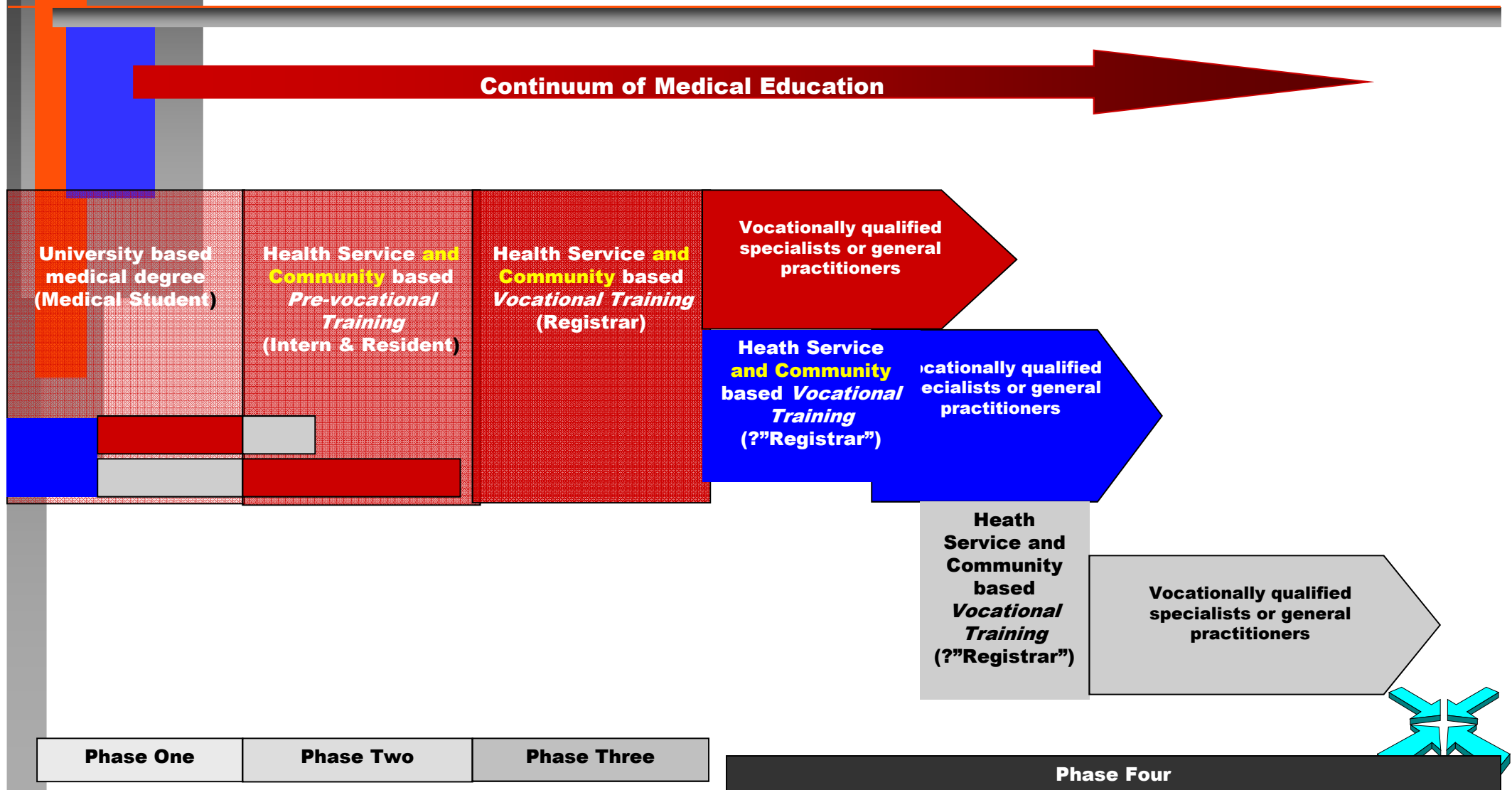
Prevocational Training – Do We Really Understand it ?



Traditional concept of “special interest” development



Realistic model of special interest development



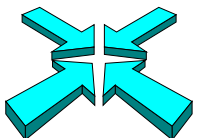
Prevocational Training – How Has It Evolved?

The internship is the focal point of the transition of medical student to physician ... and **its development has followed an erratic path.**

Evolution of many of the characteristics (of internship) has been **determined more by socioeconomic-political issues than by consideration of educational objectives.**

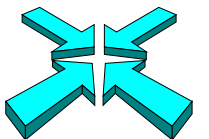
There is a **new appreciation of the role that the internship experience can play in the professional maturation of the physician.**

(Wentz et al JAMA 1984;252:3390-3394)



So.... If its not about the acquisition of a clearly defined skills in a linear and standardised way... do we really need It?

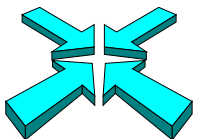
- **Registration requirements?**
- **Workforce requirements?**
- **Ensuring competency?**
- **“Streaming” individuals into appropriate postgraduate careers?**



An Evaluation of the (UK) Foundation Program – Professor John Collins

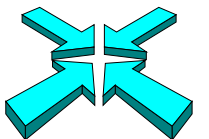
The Foundation Program has established a credible... process with a defined and distinct set of competencies to be acquired in order to progress to specialty training.

Australia (and ? New Zealand) stack up pretty well – there are virtually no issues identified by Professor Collin's review that we aren't aware of and addressing in ANZ.



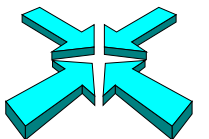
What Are The General Issues And Challenges For Prevocational Training?

- Defining the experience and the outcomes
- Ensuring optimal outcomes for new graduates and communities via robust (but streamlined) accreditation processes
- Ensuring workforce balance (both geographic and skill balance)
- Applying best practice in our approach to PVET
- Effective integration of PVET



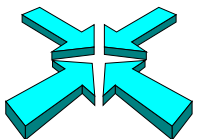
What Are The **Specific** Issues and Challenges That we are Currently Dealing With?

1. Incorporating Indigenous Health and Training into our Programs
2. National Internship Registration Standards
3. Prevocational Accreditation Framework
4. Capacity Expansion and Workforce Issues
5. Clinical Supervision
6. CPMEC/PMC Governance and resources



Indigenous Health Training

- Addressing the gap in prevocational years
- Working with AIDA to develop a collaboration framework
- Focus on mentoring and support for indigenous doctors



1. National Internship Registration

- **MBA draft internship standards**
 - Developed by AMC Working Party – CPMEC representation
 - Exposure to medicine, surgery & emergency medical care
 - Final version yet to be released
 - Guidelines on the experiences (learning objectives) required in each term based on the ACF
 - National internship assessment process
 - Requirements for part-time, interrupted and deferred internship
 - Accreditation of overseas internships



1. National Internship Registration

- MCNZ review of prevocational training requirements in NZ
- Offered 4 options for internships based on four month runs over 12-24 months
- CPMEC very interested in the options adopted
- Broader issue of harmonisation of Australian & NZ internships



2. Accreditation

- **Role of AMC in prevocational accreditation and accreditation of PMCs**
 - National prevocational accreditation framework
 - Accreditation of PMCs by the AMC
 - Role of the Prevocational Medical Accreditation Framework (PMAF)
- **Resourcing of prevocational accreditation**
 - Role of the MBA/jurisdictions
 - National funding model
- **Accreditation beyond the internship year?**

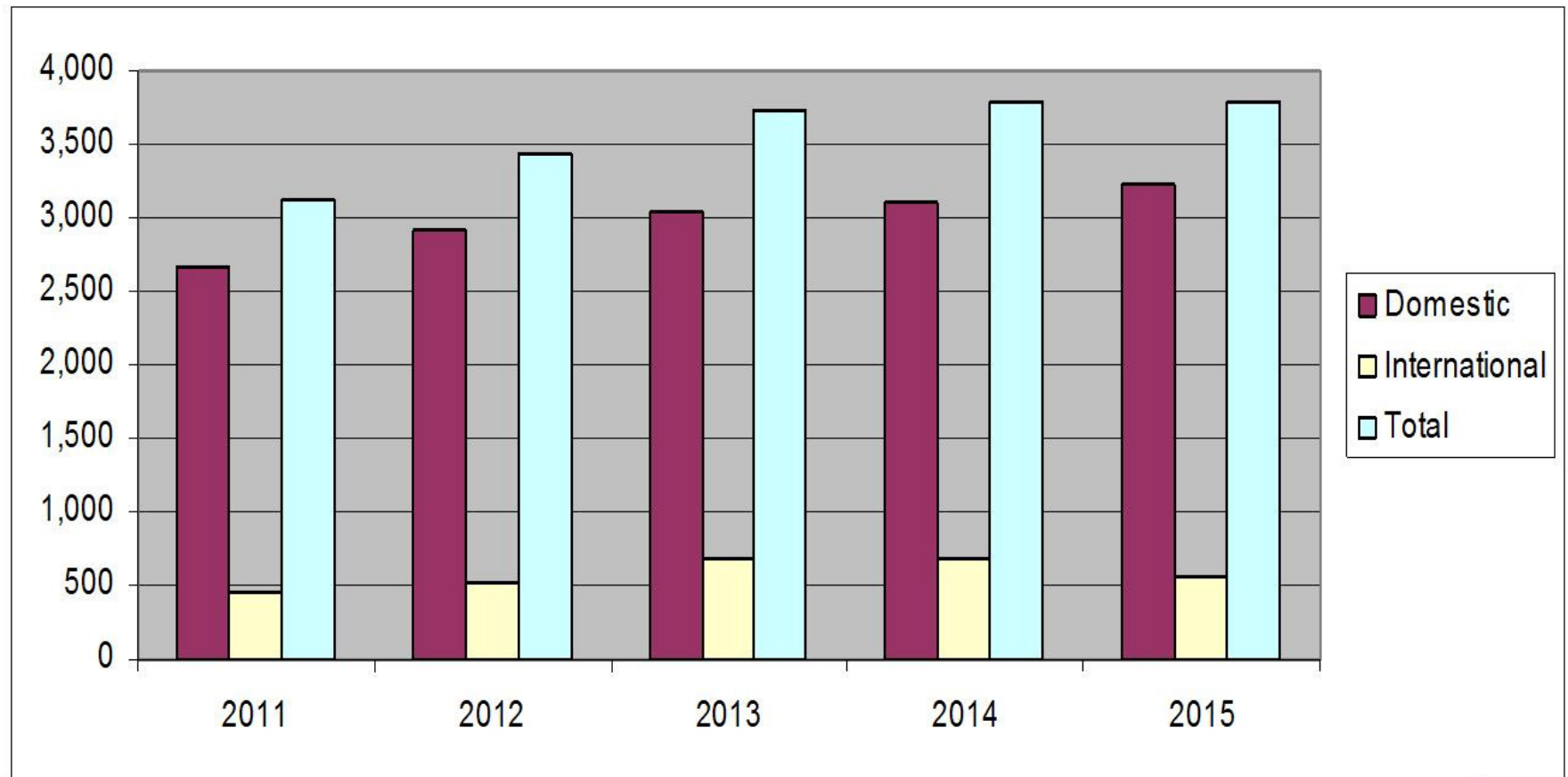


2. Accreditation

- Streamlining accreditation processes and building efficiencies across the postgraduate training continuum
- PGPPP pilots planned to consider streamlined approach in general practice
- Report on accreditation streamlining in vocational training being considered by jurisdictions



3. Capacity Expansion: Medical Graduate Numbers 2011-15



3. Capacity Expansion

- Internships for domestic students largely met
- Internships for international full fee paying students emerging as an issue
- Increase in rotations in primary care and community settings – PGPPP expansion
- Need for quality assurance to ensure education & training, supervision and welfare support for JMOs
- Pressure to increase vocational training – need to be matched with workforce and service needs; trainee preferences, etc.
- Need to factor in HWA National Training Plan
- What about IMGs?



3. Capacity Issues - Prevocational

■ Intern allocation processes

- National audit of multiple acceptances now fully accepted by all jurisdictions
- Achieve greater national consistency in priority rankings
- National process after early rounds completed?
- Significant jurisdictional resistance to any move towards a national intern allocation process



4. Clinical Supervision

- **HWA Clinical Supervision Support Program**
 - Limited involvement in postgraduate space
- **Need to support programs that are working well**
 - Teaching on the Run; CPMEC's Professional Development Program for Registrars
- **Role of HWA's Integrated Regional Clinical Training Networks**
- **Support for Directors of Clinical Training**
- **Recognition of teaching & supervision**



5. Governance & Funding

- Role of CPMEC in a shift towards a national (& trans-Tasman) approach on prevocational training matters
- PMCs are very diverse in structure, scope and accountabilities (NSW CETI cf. PMCQ) but enough common ground e.g. accreditation; quality of teaching and supervision of junior doctors; intern workforce (for most)
- Despite diversity, CPMEC has built strong collaborative culture with its members and key stakeholders to achieve significant



5. Governance

■ Internal Consultative Mechanisms:

- PMC Chairs; PMC Principal Officers ; JMO Forum Chairs; Medical Education Officers' ; Directors of Clinical Training (or equivalent) ; Prevocational Medical Accreditation Network; National Internship Allocation Working Party

■ External Stakeholder Interactions:

- Australian Government Dept. of Health and Ageing; Medical Deans; Committee of Presidents of Medical Colleges; AMACDT; Australian Indigenous Doctors' Association; Health Workforce Australia; Medical Training Review Panel (MTRP); State & Territory Health Departments; GPET; RTPs



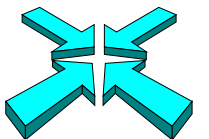
5. Funding of Prevocational Training

- **CPMEC/PMCs have narrow resource base** – no students or mandatory training program cf. medical schools and colleges
- **Void left by cessation of MTRP funding for national priority projects not filled** – possible role for HWA?
- **DoHA support has been critical in the growth of CPMEC** – has been matched a good track record of delivery
- **State/territory PMCs have limited capacity to increase funding contributions to CPMEC** – already provide significant pro bono contributions through Chairs, Principal Officers and other staff

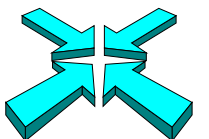


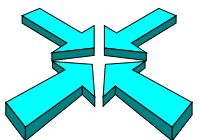
What Factors Will Influence Prevocational Training Over The Next Decade?

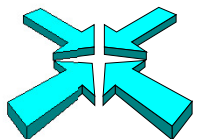
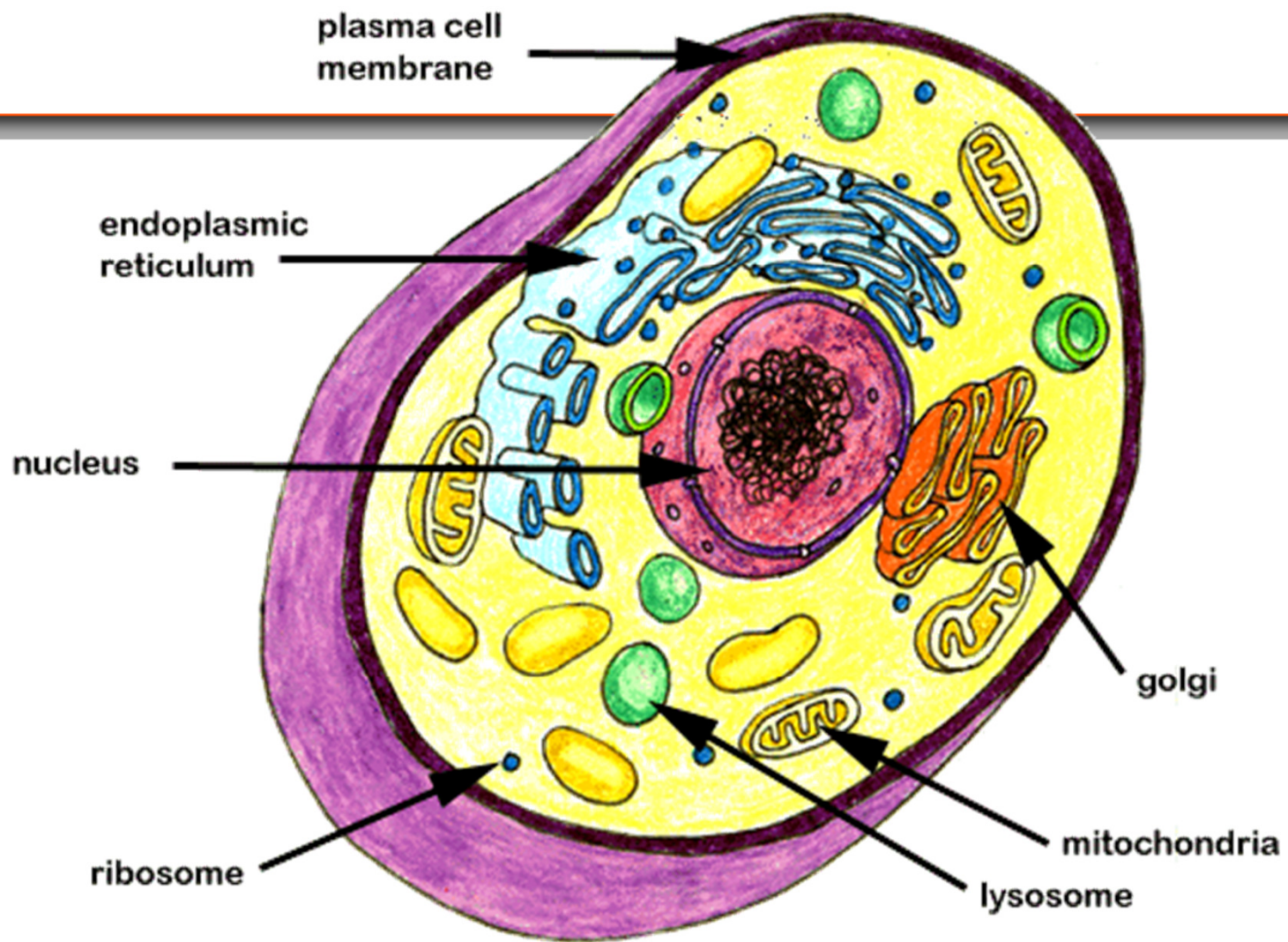
- 1. Changes in clinical service delivery**
- 2. Changes in community expectations**
- 3. Changes in workforce demographics**
- 4. Generational change**
- 5. Competition for educational resource**
- 6. Accelerating evolution of the health system**

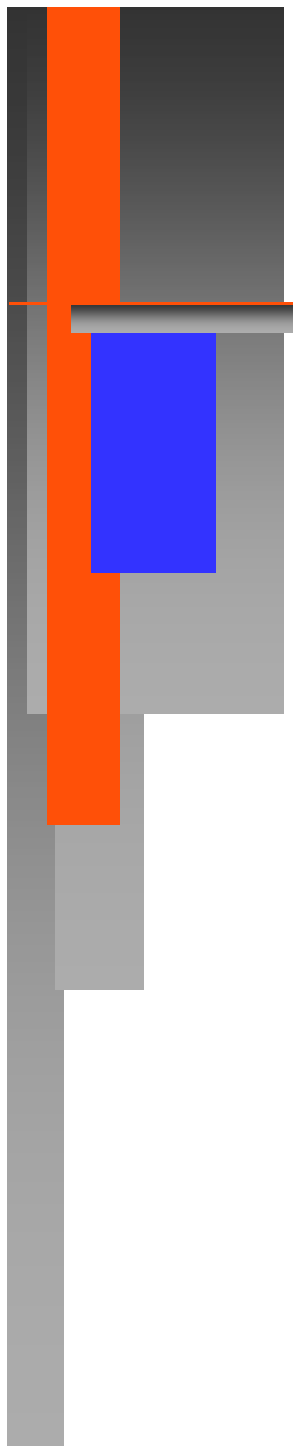
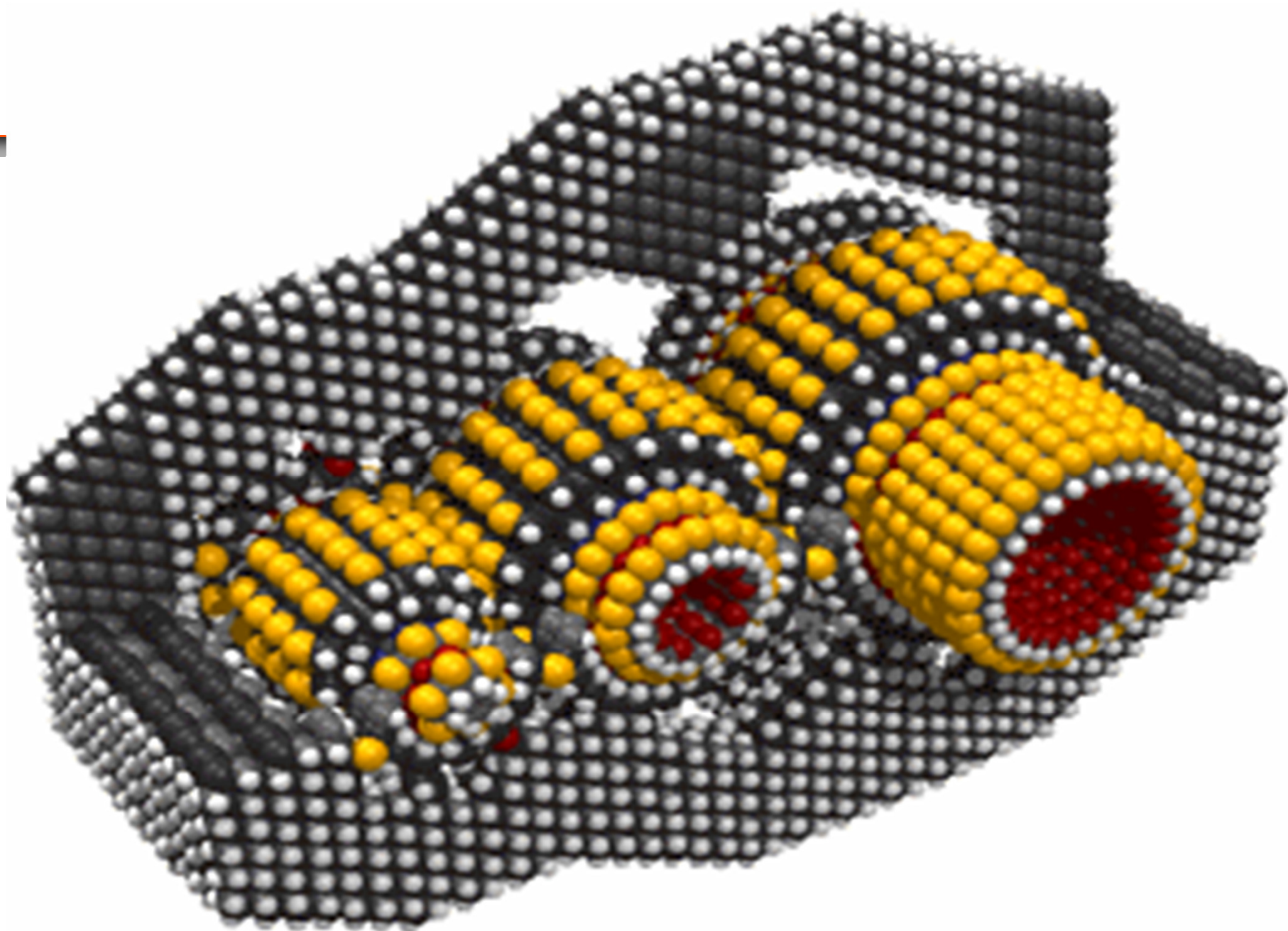


Changes in Clinical Service Delivery



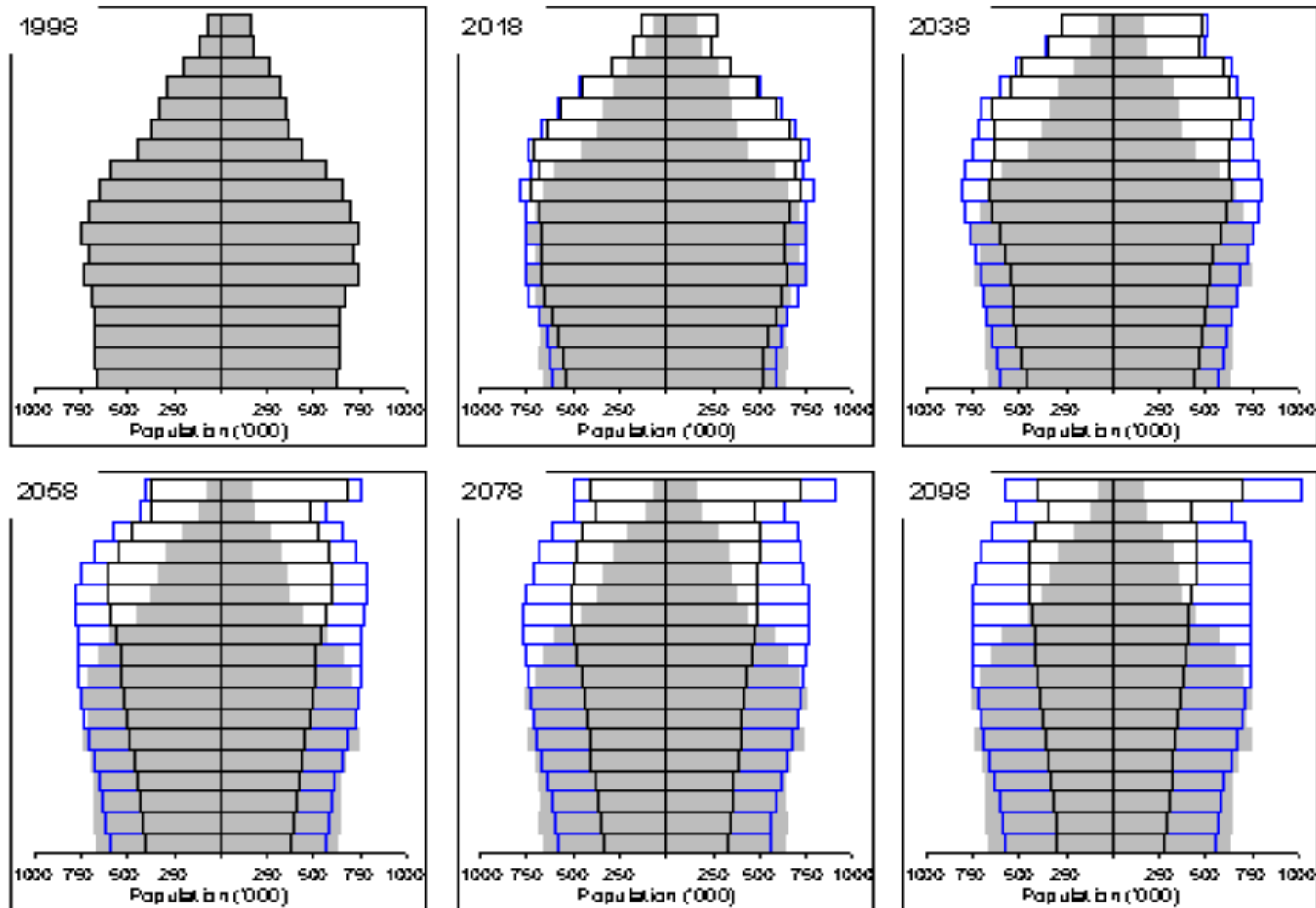




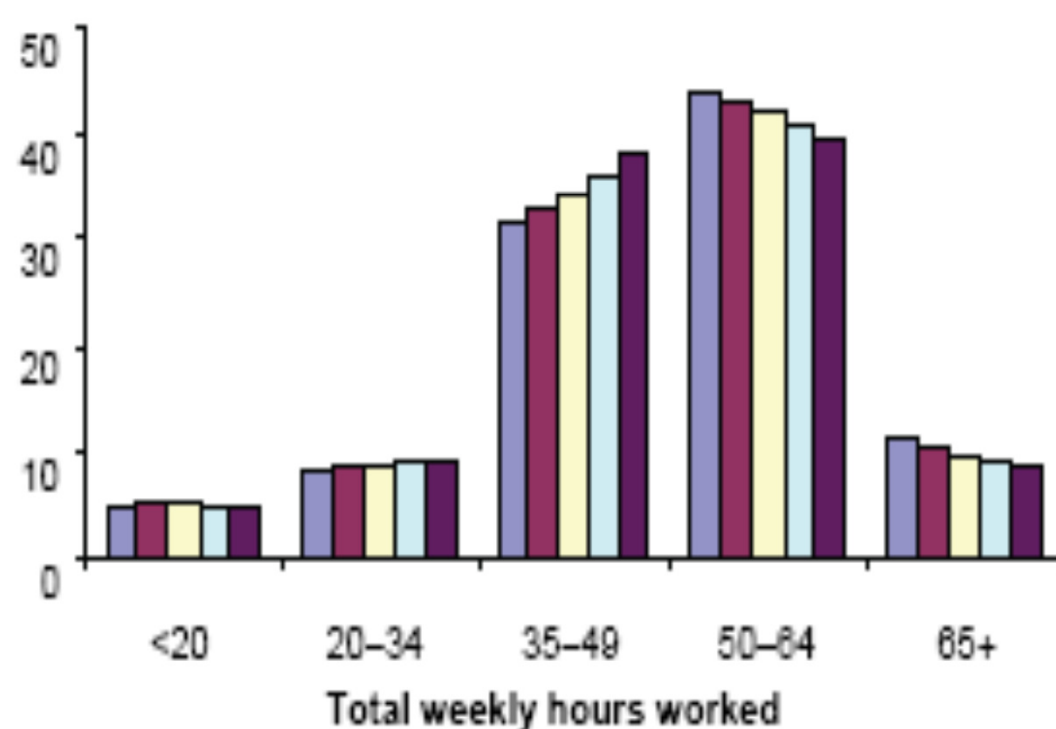


Changes in Community and Workforce Demographics

Figure 1. Selected 'Standard' population pyramids, Australia, 1998–2098



Per cent



Average hours

2001 48.4

2002 47.7

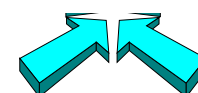
2003 47.5

2004 47.1

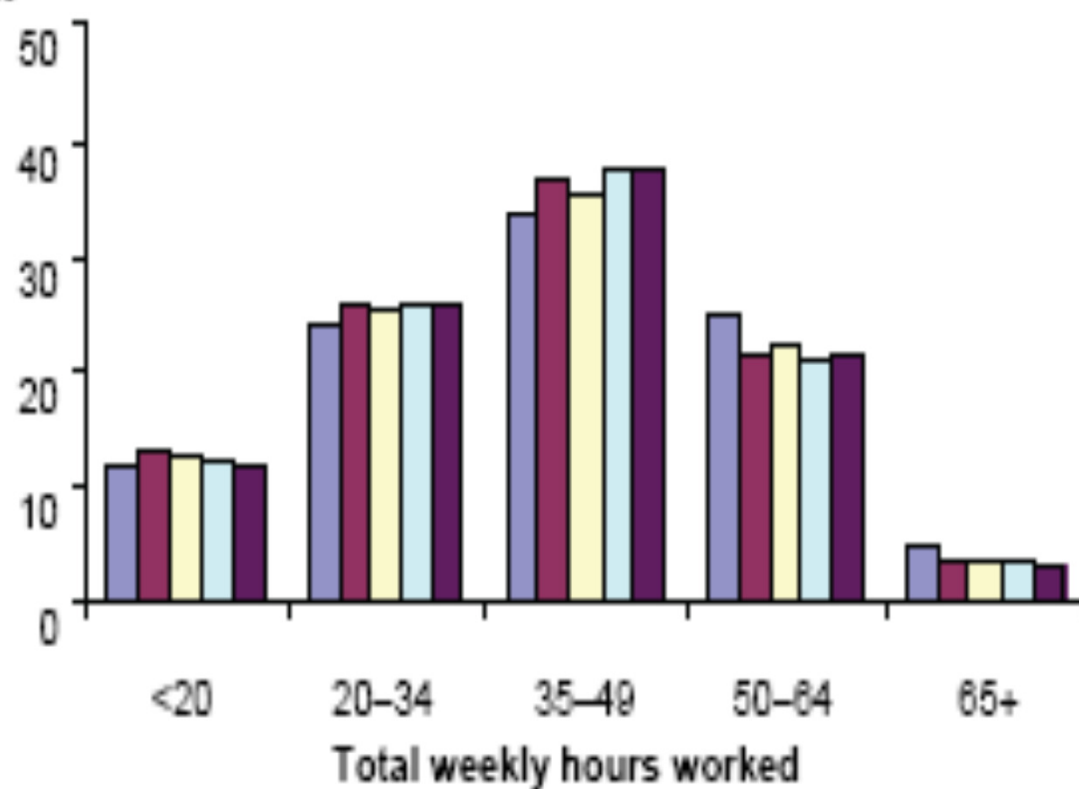
2005 46.7

Sources: AIHW Medical Labour Force Surveys, 2001 to 2005.

Figure 3: Employed male medical practitioners by total hours worked per week, 2001 to 2005



Per cent



2001
2002
2003
2004
2005

Average hours

2001 38.8

2002 37.3

2003 37.8

2004 37.6

2005 37.6

Sources: AIHW Medical Labour Force Surveys, 2001 to 2005.

Figure 4: Employed female medical practitioners by total hours worked per week, 2001 to 2005











Generational Change



Lifestyle!

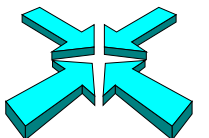
Bah, Humbug! 

Don't Quit This Day Job

I'm a doctor and a mother of four, and I've always practiced medicine full time. When I took my board exams in 1987, female doctors were still uncommon, and we were determined to work as hard as any of the men.

Today, however, increasing numbers of doctors — mostly women — decide to work part time or leave the profession.

*KS Sibert — Anaesthetist - Los Angeles
Opinion piece in the New York Time 12/06/2011*

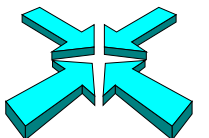


KS Sibert – (Cont)

This may seem like a personal decision, but it has serious consequences for patients and the public.

It isn't fashionable (and certainly isn't politically correct) to criticize "work-life balance" or part-time employment options.

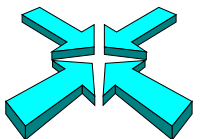
..... I have great respect for stay-at-home parents, and I think it's fine if journalists or chefs or lawyers choose to work part time or quit their jobs altogether. But it's different for doctors. Someone needs to take care of the patients.



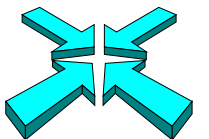
Competition for Educational Resources

How do we address this?

1. Effectively utilise the IT revolution
2. Argue to maintain personal supervision and face to face training where appropriate
3. Articulate the differences between 'clinical' vs. 'non-clinical' education and training
4. Be prepared to share our resources generously



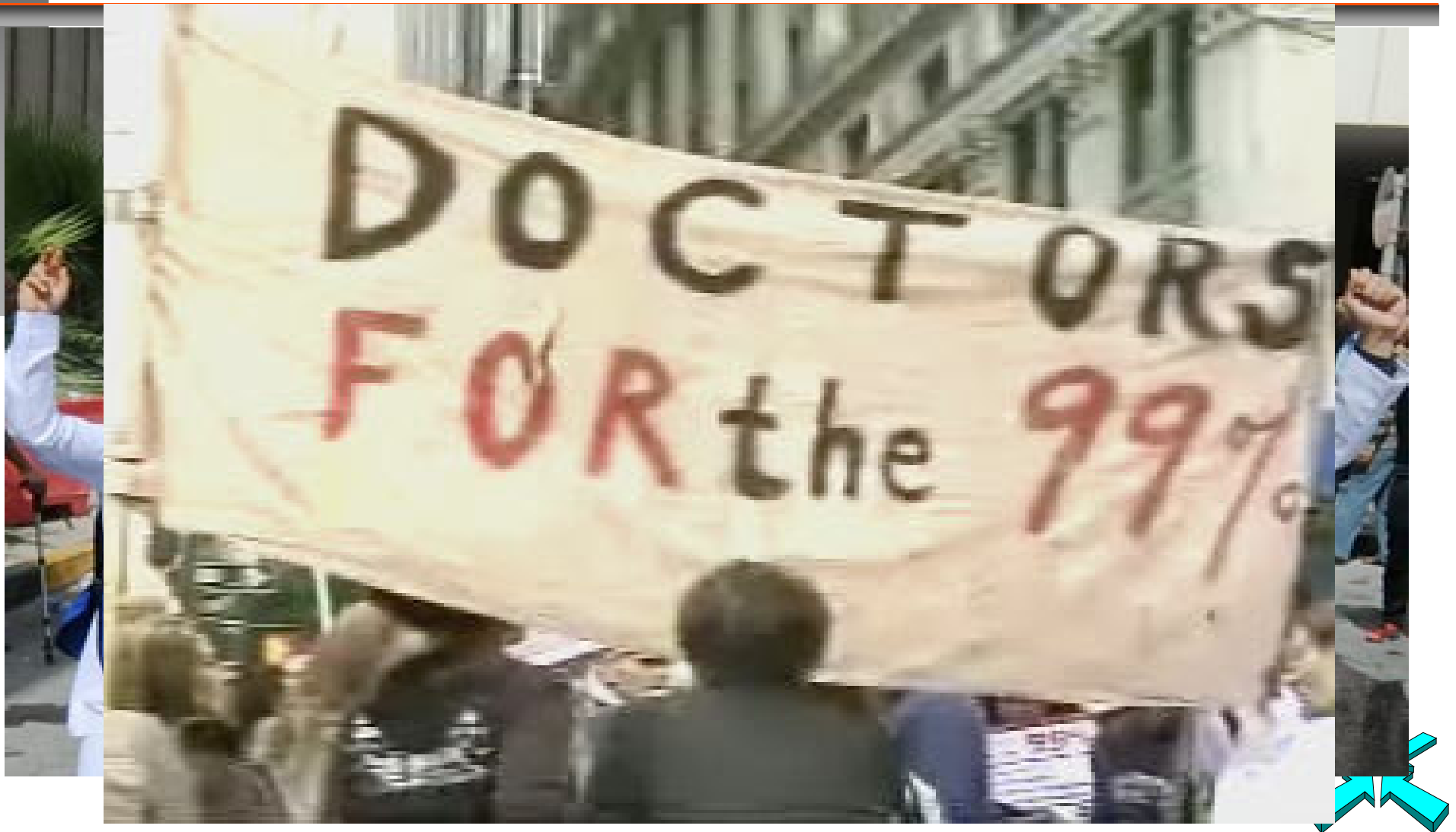
Team Based Care



The Role of the Colleges



What Keeps Me Awake at Night?



What Does This Mean for the CPMEC?

Maintaining and improving standards, while...

- **Supporting the development of our new generations of medical graduates, and...**
- **Meeting community expectations...**
- **In a changing health landscape**

