AMA (NSW) DOCTOR-IN-TRAINING 2011 STATE ELECTION PRIORITIES

SUMMARY OF PROPOSALS

1. **Include education and training of medical staff as a key performance indicator (KPI) with a significant weighting in Local Health Network chief executive officers' performance agreements**
   - This recommendation is supported by Peter Garling SC in his final report of the 2008 Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals
   - KPIs should include minimum targets for 'pager-free' training as a proportion of doctors' ordinary rostered hours (consistent with Garling's recommendations of 20 per cent for PGY1 and 10 per cent for PGY 2) and targets for successful completion of internship, registrar exams and AMC exams by doctors-in-training

2. **Support the actions articulated in the joint statement from the AMA Medical Training Summit of September 2010, in particular a guarantee of internship positions and the number of training positions recommended by the proposed national analysis**
   - This needs to include a guarantee of internship positions to all local and international full fee-paying medical students at NSW universities (except for students notified in writing prior to enrolment that they would not be guaranteed an internship upon completion of their degree)
   - It also needs to include a NSW Government commitment to participate in a national analysis of community demand for medical services through until 2025 and the associated medical workforce requirements – broken down according to specialty area and location – and to provide the number of prevocational and vocational training positions recommended by this analysis for NSW

3. **Ensure all interns and PGY2 doctors spend a minimum of 20 per cent and 10 per cent of their time respectively participating in training programs and establish a fully-funded Medical Education Unit within each Local Health Network to support this objective**
   - Recommendation 37 of the Garling Report called for all prevocational clinical staff to spend a minimum of 20 per cent of their ordinary rostered time in PGY1, and a minimum of 10 per cent of their ordinary rostered time in PGY2, participating in training programs
   - Fully-funded Medical Education Units within the Local Health Networks would be responsible for the development, co-ordination, delivery and evaluation of all education and training activities for prevocational doctors
   - A key member of their staff should be Medical Education Registrars, i.e. registrars employed on 12-month contracts with only minimal service provision duties whose focus is on assisting the training of junior doctors and in developing their own expertise in clinical education and academic medicine

4. **Ensure that 30 per cent of all doctors' ordinary rostered time (PGY2 and above) is protected as 'clinical support time' for teaching and supervision, administration and professional development**
   - The demands on clinicians to undertake teaching, administrative and other clinical support duties in the public health sector are increasing and thus there need to be provisions that explicitly recognise and allocate time for the duties that are not directly associated with the diagnosis or management of individual patients
   - The allocation of 30 per cent includes time for the doctors' own education and training

5. **Commission an independent auditor to develop an audit plan and conduct annual audits on each Local Health Network's education and training performance**
   - The results should be reported in league tables made publicly available online

AMA (NSW) DOCTOR-IN-TRAINING 2011 STATE ELECTION PRIORITIES

PREAMBLE

New South Wales (and Australia generally) is currently experiencing a severe medical workforce crisis, largely as a result of poor policy decisions and inadequate workforce planning. We are highly reliant on the contribution made by temporary resident international medical graduates, especially in rural NSW and the public hospital system.

Since 2004, the Commonwealth Government has responded to medical workforce shortages by taking several steps to significantly increase the number of medical school places across the country. Graduations from NSW medical schools are projected to almost double over the next few years, from 577 in 2009 to 1,096 in 2014 (Medical Training Review Panel, 2010, pp. 13-14).

NSW needs all of these graduates to become fully-trained doctors if we are to resolve the existing severe medical workforce shortages. Only by committing to the employment and training of these additional graduates will we ensure that there are sufficient doctors to care safely for our growing and ageing population. Additional doctors will optimise patient care, reduce waiting times and assist achievement of safe working hours.

The Australian Medical Association New South Wales (AMA) has consulted widely to develop the five proposals within this document that, if implemented, will significantly improve patient care by increasing the number of fully-trained doctors and by improving the education and training of junior doctors. The proposals will also enhance the competitiveness of the NSW health system as an employer of choice, ensuring we employ, train and retain the best and brightest clinicians in Australia.

NB: Throughout the document we have used PGY1 or intern to mean Postgraduate Year 1 and PGY2 to mean Postgraduate Year 2.

1. EDUCATION AND TRAINING IN LOCAL HEALTH NETWORK CHIEF EXECUTIVE OFFICERS' PERFORMANCE AGREEMENTS

The AMA calls for the inclusion of education and training of medical staff as a key performance indicator with a significant weighting in Local Health Network chief executive officers' performance agreements

Education and training within the NSW health system is deficient, due to a culture that prioritises cost containment and service delivery over other fundamental functions of the health system. For both students and teachers, insufficient time is quarantined from the demands of service delivery and administration.

The current situation jeopardises patient safety and requires systemic cultural change. Education and training must be accepted as "part of the 'core business' of the delivery of health care in NSW" (Garling, 2008, p. 351) because its proper provision is vital "to constantly achieve a high standard of patient care; to ensure the safety of patients; to ensure that medical treatment is delivered in the most sensible and efficient manner; and to attract and retain the workforce" (Garling, 2008, p. 322).

The AMA supports the comments made by Peter Garling SC following his Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals, *viz.*:

In my view, a useful tool to enhance the importance of education and training in NSW public hospitals is to introduce a high level performance requirement for hospital management relating to education and training. Until there are meaningful performance assessments that require hospital management to deliver education and training, education and training will continue to be undervalued because of its intangible benefits. There is in my view a need for senior administrative staff (Chief Executives, General Managers and other health service managers) to be given a role in managing the conflict between education and training and service provision. In other words, training needs to be part of the public health system's core business.

Recommendation 30: Benchmarks which adequately measure the extent of the delivery of postgraduate clinical education and training should be included in performance agreements between NSW Health and area health services and statutory health corporations. (Garling, 2008, p. 324)

Key performance indicators should include:

- Hours spent in 'pager-free' training as a proportion of doctors' ordinary rostered hours
  - Minimum target of 20 per cent for PGY1 and 10 per cent for PGY2
  - Training must be defined as dedicated 'pager-free' teaching outside of the usual work environment, i.e. in addition to the valuable teaching provided by daily ward rounds
- Rate of successful completion of internship, registrar exams and AMC exams by doctors
  - Target of progressive improvements each year, specific to each Local Health Network based on its *pro forma* performance in 2010
- Accreditation performance of the hospitals within the LHN as training sites for prevocational and vocational education, i.e. by Clinical Education and Training Institute NSW (CETI) and the specialist medical colleges
  - Target of 100 per cent with no qualifications

2. SUPPORT THE ACTIONS ARTICULATED IN THE JOINT STATEMENT FROM THE AMA MEDICAL TRAINING SUMMIT OF SEPTEMBER 2010, IN PARTICULAR A GUARANTEE OF INTERNSHIP POSITIONS AND THE NUMBER OF TRAINING POSITIONS RECOMMENDED BY THE PROPOSED NATIONAL ANALYSIS

The AMA calls for support for the actions articulated in the joint statement from the AMA Medical Training Summit of September 2010, in particular a guarantee of internship positions and the number of training positions recommended by the proposed national analysis

The increases in medical school graduates are the long-term solution to Australia's medical workforce shortage. These increases must be matched by an increase in training places right through to the completion of vocational training with a specialist medical college. Health Workforce Australia (HWA) has been established to advise on workforce planning and its recommendations will need to be accepted and implemented by all state health departments.

On 29 September 2010, the Australian Medical Association hosted a summit in Canberra to discuss and develop practical solutions to the current problems in medical training in Australia. At the conclusion of the summit, a joint statement was issued. The AMA calls for implementation of the recommendations of the joint statement, in particular:

- Guaranteed internship (PGY1) positions for all local and international full fee-paying medical students at NSW universities [except for students notified in writing prior to enrolment that they would not be guaranteed an internship upon completion of their degree]

- NSW Government support for a Medical Workforce Planning Advisory Committee to undertake, inter alia, an analysis of community demand for medical services through until 2025 and the associated medical workforce requirements – broken down according to specialty and location
- A guarantee to meet the training needs of the increased number of medical school graduates with a co-ordinated and fully-funded increase at the level recommended by the above analysis in:
  - Clinical training places for medical students
  - Intern and prevocational training places
  - Vocational (specialist) training places

(Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand and Confederation of Postgraduate Medical Education Councils, 2010)

For the full list of recommendations, please see Appendix A (p. 7).

3. ENSURE ALL INTERNS AND PGY2 DOCTORS SPEND A MINIMUM OF 20 PER CENT AND 10 PER CENT OF THEIR TIME RESPECTIVELY PARTICIPATING IN TRAINING PROGRAMS AND ESTABLISH A FULLY-FUNDED MEDICAL EDUCATION UNIT WITHIN EACH LOCAL HEALTH NETWORK TO SUPPORT THIS OBJECTIVE

The AMA calls for minimum guaranteed protected teaching time for all interns and PGY2 doctors – 20 per cent of ordinary rostered time for PGY1 and 10 per cent for PGY2 – and a fully-funded Medical Education Unit within each Local Health Network to support this objective

Recommendation 37 of the Garling Report (Garling, 2008, pp. 354-355) calls for all prevocational clinical staff to be required to spend a minimum of 20 per cent of their ordinary rostered time in Year One and a minimum of 10 per cent of their time in Year Two participating in training programs. This Recommendation needs to be implemented to address the common problem of training being neglected because of the pressure of other demands.

To support this objective, the AMA calls for the establishment of at least one fully-funded Medical Education Unit (MEU) within each LHN for the purpose of development, co-ordination, delivery and evaluation of all education and training activities for prevocational doctors. LHNs with large numbers of prevocational trainees should establish multiple MEUs. At least once per annum, a medical education conference should be hosted by CETI for all MEU staff across the state to share best practice and collaborate on common initiatives.

Each MEU would be overseen by a Director of Medical Education (if also a practicing clinician, 0.5 Full Time Equivalent) and staffed by Medical Education Registrars and Administrative Support Officers. These positions are in addition to and support of the existing Director of Prevocational Education and Training roles at each hospital. By 2014, each major teaching hospital should employ at least two Medical Education Registrars.

The role of the MEU would be to:

1. Co-ordinate and deliver a formal medical education program based on the *Australian Curriculum Framework for Junior Doctors* (Confederation of Postgraduate Medical Education Councils, 2009), for PGY1 and PGY2 medical officers
2. Ensure all prevocational clinical staff spend a minimum of 20 per cent of their ordinary rostered time in PGY1 and a minimum of 10 per cent of their time in PGY2 participating in training programs
3. Develop and implement innovative training programs, including simulations (Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand and Confederation of Postgraduate Medical Education Councils, 2010)

4. Develop and implement technology required for ensuring equity in access to quality teaching and training for prevocational doctors in all locations, including videoconferencing and remote simulation training
5. Identify, develop and fund training programs that give junior and senior doctors the skills they need to teach and train medical students and other junior doctors (Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand and Confederation of Postgraduate Medical Education Councils, 2010)
6. Regularly evaluate all education programs, reporting annually on education and training performance and strategy to the LHN's governing council

For further detail, please see Appendix B (p8).

4. PROTECTED 'CLINICAL SUPPORT TIME' FOR PGY2 DOCTORS AND ABOVE

The AMA calls for 30 per cent of all doctors' ordinary rostered time (PGY2 and above) to be protected as 'clinical support time' for teaching and supervision, administration and professional development

The demands on clinicians to undertake teaching, administrative and other clinical support duties in the public health sector are increasing as the demand for clinical services grows. Their responsibilities will become unmanageable unless there is recognition and allocation of time for the duties that are not directly associated with the diagnosis or management of individual patients. The AMA calls for:

- NSW Health to increase its awareness of the critical importance of clinical support time to the functioning of a quality health service. Clinical support time is not optional and provides the opportunity for clinicians to carry out core professional activities and be properly trained
- NSW Health to support the inclusion of clinical support time in job descriptions and staffing models for all posts. This will improve job satisfaction and morale in the public health sector, assist with recruiting and retaining staff and improve the efficiency and quality of care
- 30 per cent of ordinary remunerated time to be the minimum benchmark for clinical support time for clinicians (PGY2 and above). This is to cover their own education and training plus those activities detailed in Appendix C (p. 8). Clinicians with formal management responsibilities as head of department or in other senior roles, and those who are supervisors of training, should have an additional allocation of time for these roles. Locums require clinical support time commensurate with the clinical duties undertaken.

(Australian Medical Association, 2009)

5. INDEPENDENT AUDITING OF EDUCATION AND TRAINING PERFORMANCE

The AMA calls for an independent auditor to develop an audit plan and conduct annual audits of the education and training performance of each Local Health Network

An independent auditor should be commissioned to develop an audit plan and conduct annual audits of the education and training performance of each LHN, with the scope including but not limited to the measures in senior management's performance agreements (see policy point 1).

The auditor should report to the chairpersons of the LHN governing councils and to the New South Wales Minister for Health.

The results should be reported in league tables made publicly available online.

****Ends****

APPENDIX A

Full list of recommendations referred to in policy point 2: Support the actions articulated in the joint statement from the AMA Medical Training Summit of September 2010, in particular a guarantee of internship positions and the number of training positions recommended by the proposed national analysis

On 29 September 2010, the Australian Medical Association hosted a summit in Canberra to discuss and develop practical solutions to the current problems in medical training in Australia. At the conclusion of the summit, a joint statement was issued. The AMA calls for the implementation of the recommendations of the joint statement, *viz.*:

- Guarantee internship (PGY1) positions to all [local and] international full fee-paying medical students at NSW universities [except for students notified in writing prior to enrolment that they would not be guaranteed an internship upon completion of their degree]. *Refer to (in the full joint statement): pp. 2,6*
- HWA to establish a Medical Workforce Planning Advisory Committee to complete certain medical workforce studies by the end of 2011, including an analysis of community demand for medical services through until 2025 and the associated medical workforce requirements – broken down according to specialty and location
- Guarantee to meet the training needs of the increased number of medical school graduates with a co-ordinated [and fully-funded] increase [at the level recommended by HWA] in:
    - Clinical training places for medical students
    - Intern and prevocational training places
    - Vocational (specialist) training places. *Ref: p. 2*
- Ensure that bodies such as the Medical Training Review Panel (MTRP) and HWA are able to access all available data on projected training positions to inform their medical workforce planning activities. *Ref: p. 4*
- Oppose the introduction of new medical schools and significant increases in medical student numbers until it has been established that there are sufficient training posts and clinical supervisors to provide prevocational and vocational training. *Ref: p. 5*
- Support the development of nationally-consistent intern allocation processes and share information on intern applications and acceptances with the other states/territories. *Ref: p. 5*
- Support the MTRP's biennial collection of data to monitor the expansion of prevocational and vocational training positions supported by HWA. *Ref: p. 7*
- Set aside quarantined funding to support hospitals to meet appropriate benchmarks for 'protected teaching time' for clinicians. *Ref: p. 7*
- Support the identification, development and funding of innovative training programs, including simulated training and teaching. *Ref: pp. 7-8*
- Support the identification, development and funding of training programs that give junior doctors the skills they need to teach and train medical students and other junior doctors. *Ref: p. 8*
- Support the full utilisation of opportunities for clinical experience that are available in general practice surgeries and private and community settings. *Ref: p. 8*
- Properly fund CETI so that it can accredit the number of prevocational training positions that will be required into the future. *Ref: p. 9*

(Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand and Confederation of Postgraduate Medical Education Councils, 2010)

6. APPENDIX B

Further detail on policy point three: Ensure all interns and PGY2 doctors spend a minimum of 20 per cent and 10 per cent of their time respectively participating in training programs and establish a fully-funded Medical Education Unit within each Local Health Network to support this objective

MEDICAL EDUCATION REGISTRARS

The new role of 'Medical Education Registrar' will assist with the on-floor training of junior doctors and support the career development of those registrars with a strong interest in clinical education and academic medicine. Candidates for these roles will be registrars already enrolled in a specialist medical college's training program.

Contracts of 12 months' duration will be offered with a requirement to undertake a formal education qualification during that time and/or lead or participate in an educational research project. The registrars will work as a member of the Medical Education Unit to assist with the planning and delivery of educational activities for junior doctors. Where applicable, they will also work with the specialist medical colleges to design and deliver training.

The position should be modelled on its well-developed interstate equivalents, such as that in Queensland (Queensland Health, 2010), and designed to satisfy the requirements of the specialist medical colleges' sub-specialties in Academic Medicine, such as that being piloted in 2011 by the Royal Australian College of Physicians (Newton, 2010).

PROTECTED EDUCATION TIME

The AMA calls for a commitment to Recommendation 37 of the Garling Report (Garling, 2008, pp. 354-355):

> *… (c) that all prevocational clinical staff enrolled in [CETI's] programs be required to spend a minimum of 20% of their ordinary rostered time in Year One and a minimum of 10% of their time in Year Two participating in the training programs; and*
>
> *(d) that the clinical education and training program for prevocational clinical staff include at least four different components, namely:*
>
> *(i) Formal teaching to which currently employed and contracted senior clinical staff would contribute;*
> *(ii) E-learning by self-completed modules;*
> *(iii) Simulation training conducted by senior clinical staff at simulation centres and facilities; and*
> *(iv) Clinical skill modelling where postgraduate clinical staff are supernumerary for the relevant mandatory time to enable observation of, and modelling of, clinical skills being demonstrated by senior clinicians.*

Whilst 100 per cent attendance may be unachievable, a reasonable minimum is 70 per cent. To protect doctors' attendance, training time must be rostered and 'pager-free'. 'Pager-free' can be achieved as best suits the individual hospital, for example hosting training off-site, diverting pages to registrars, physically handing pagers to registrars, leaving pagers with a clerk or double-scheduling a shift. It must be supported by explicit knowledge of the scheduled protected teaching time amongst consultants, registrars, nursing unit managers and nurses.

PAID EDUCATION TIME

An explicit policy must guarantee that attendance at out-of-hours training sessions is paid and that any overtime consequent to attending the sessions is paid.

MORE LEARNING FOR INTERNS IN EMERGENCY (MOLIE)

In emergency departments, an equivalent program to Queensland Health's *More Learning for Interns in Emergency* (MoLIE) should be trialled. MoLIE involves interns in emergency departments spending a full day a week in clinically-relevant, active training. It has the benefits of better training interns in emergency medicine skills, increasing by 25 per cent the number of interns who can be accommodated in the essential emergency rotations, protecting teaching time and increasing opportunities for more senior doctors to teach.

TEACHING LISTS, CLINICS AND ROUNDS

As part of their training, junior doctors should be given the opportunity to attend specific 'teaching lists, clinics and rounds' at least once a month. These activities would be expected to run longer than normal in order to allow ample time for junior doctors to learn and practice new skills under the supervision of a specialist. As called for above, an explicit policy must guarantee that overtime consequent to these sessions running longer than normal is paid.

The 'bedside teaching' nature of this training is a highly effective mode of learning which simultaneously performs a service delivery function. These rostered teaching lists, clinics and rounds would be included in the 30 per cent clinical support time referenced in policy point four and in Garling's recommended minimum rostered time for teaching referenced in policy point three and above.

TEACHING THE TEACHERS

The majority of prevocational doctors' training is delivered by registrars, yet they have not necessarily been offered any formal training in teaching, nor is there formal recognition of the importance of this aspect of their role. With the rising number of medical school graduates (almost doubling from 2009 to 2014), it is essential that teaching skills are built as widely as possible within the system so that we have the capacity to train all these additional trainees.

As part of the establishment of MEUs, the AMA calls for formal recognition and support of residents' and registrars' key role in the education of their juniors. Teaching – including learning how to teach – would be included in the 30 per cent 'clinical support time' called for in policy point four. Support should include training programs such as *Teaching on the Run* and graduate certificate/diploma or master's level courses. Access to and funding for *Teaching on the Run* workshops should be available statewide by July 2011 to all doctors who would like to participate.

APPENDIX C

Activities includable as 'clinical support time'

As per Annex A of the Australian Medical Association's 2009 policy, *Clinical Support Time for Public Hospital Doctors* (Australian Medical Association, 2009).

Teaching and training

For senior clinicians

- Supervision and oversight of doctors-in-training and undergraduate medical students
- Teaching activities for undergraduate, prevocational, vocational and allied health students
- Teaching activities include lectures, case presentations, workshops, grand rounds and associated preparation time
- In-training assessment activities, including feedback sessions with doctors-in-training
- Maintenance and improvement of teaching skills

For residents and registrars

- Supervision and oversight of doctors-in-training and undergraduate medical students
- Protected training time for attendance at tutorials, lectures, workshops and conferences
- Examination preparation time
- In-training assessment activities, including feedback with clinical supervisors
- Teaching activities for undergraduate and vocational students
- Teaching activities, including lectures and case presentations, grand rounds and associated preparation time

Continuing professional development

- Attendance or presentation at departmental and regional continuing education sessions
- Attendance or presentation at local and international conferences and workshops
- Journal clubs
- Peer review
- Self-directed, continuous learning activities including reading and review

Maintenance of professional standards

- Specialty college activities including board, committee and examination work
- Professional body activities at state and national level
- Participation on government and non-government boards and committees

Audit & quality assurance

- Audit and appraisal activities at individual, departmental and hospital levels
- Quality assurance activities, including collection, analysis and presentation of clinical data
- Peer review
- Morbidity, mortality and critical incident review
- Clinical credentialling (delineation of clinical privileges) activities

Occupational health and safety

- Personal participation in programmes to safeguard health and well-being
- Development and supervision of OH&S programs for co-workers

Research

- Clinical trials and studies
- Laboratory-based research
- Reading time
- Preparation time

- Collaboration time

Healthcare liaison

- Non-patient contact including liaison with carers, relatives and other health professionals

Administrative

- Rostering
- Committee work at hospital, government and community levels
- Administrative paperwork and communication
- Data collection and report preparation to meet hospital or government requirements and requests

Managerial

- Human resource management
- Financial resource management
- Clinical pathway development and implementation

This is not an exhaustive list but outlines some common clinical support activities.

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