

Australian Medical Workforce Advisory Committee

Career Decision Making By Doctors In Vocational Training

**Proceedings of the Workshop Held to Consider the
Findings of the AMWAC Medical Careers Survey 2002 and
Possible Future Directions for Vocational Medical Training**

Convened on 3 November 2003

AMWAC Occasional Paper 2003

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ABBREVIATIONS

AHMAC	Australian Health Ministers' Advisory Council
AHWOC	Australian Health Workforce Officials' Committee
AMWAC	Australian Medical Workforce Advisory Committee
GP	General Practitioner
PGMC	Postgraduate Medical Education Council
PGY	Postgraduate year
UK	United Kingdom

TERMS OF REFERENCE OF THE AUSTRALIAN MEDICAL WORKFORCE ADVISORY COMMITTEE

The Australian Health Ministers' Advisory Council (AHMAC) established AMWAC to assist with the development of a more strategic focus to medical workforce planning in Australia and advise on national medical workforce matters, including workforce supply, distribution and future requirements.

AMWAC reports to AHMAC, and through AHMAC to the Australian Health Ministers' Conference. AMWAC is one of three AHMAC workforce committees, the other two being the:

- Australian Health Workforce Officials' Committee; and
- Australian Health Workforce Advisory Committee.

The Australian Health Workforce Officials' Committee (AHWOC) provides a forum for reaching agreement on key national level health workforce issues requiring government collaborative action and provides advice on health workforce issues to the Australian Health Ministers' Advisory Council (AHMAC). AHWOC also has a central role to play in co-ordinating the implementation of the recommendations arising from the workforce planning analysis undertaken by AHWAC and AMWAC. AHWOC comprises a nominee from the Australian/State/Territory health departments and the Australian Department of Education, Science and Training. The Australian Health Workforce Advisory Committee fulfils a similar role to AMWAC but with a focus on the nursing, midwifery and allied health workforces.

AMWAC oversees a medical workforce research program which is approved by AHMAC. This specific medical program is complementary to, and linked with, the broader health workforce research agenda overseen for AHMAC by AHWOC.

The terms of reference AMWAC operates under are:

1. To provide advice to the Australian Health Ministers' Advisory Council on a range of medical workforce matters, including:
 - the structure, balance and geographic distribution of the medical workforce in Australia;
 - medical workforce supply and demand; and
 - the number and distribution of education and training places needed to meet future demand as suggested by patterns of supply, population health status, practice developments and changing models of health care.
2. To develop models for describing and predicting future medical workforce requirements, and provide advice on its methodology, including indicators and benchmarks, for use by employing and workforce controlling bodies including governments, specialist medical colleges and tertiary institutions at:
 - national level;
 - state and territory levels; and
 - intra-state and territory.

3. To oversee the establishment and development of data collections concerned with the medical workforce, and analyse and report on those data to assist workforce planning.
4. To work in co-ordination and co-operation with the Australian Health Workforce Officials' Committee (AHWOC) in the assessment of the relationship between medical workforce requirements and new or alternative workforce structures, profiles and broader health human resources planning requirements.
5. To provide AHMAC with advice as requested on:
 - best practice models of care;
 - future service delivery and workforce developments; and
 - dynamic scenario planning for the medical workforce.
6. To take into account in its planning, and provide advice in its reports, on information on evidence based practice and outcomes.
7. To advise AHMAC on strengths and weaknesses of possible approaches to achieving desirable workforce supply in accordance with quality health care practices.

MEMBERSHIP OF THE AUSTRALIAN MEDICAL WORKFORCE ADVISORY COMMITTEE

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Dr Jeannette Young Executive Director, Medical Services, Princess Alexandra Hospital, Brisbane

Chair of the Australian Health Workforce Officials' Committee

Mr John Ramsay Secretary, Tasmanian Department of Health and Human Services

Nominees of the Australian Health Ministers' Advisory Council

Mr Robert Wells First Assistant Secretary, Health Services Improvement Division, Department of Health and Ageing

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AMWAC members have been appointed until 31 December 2005.

1. INTRODUCTION

Important issues relating to the vocational training of medical practitioners were raised by a survey of doctors in vocational training conducted by AMWAC in September 2002 (AMWAC 2003.3). The survey, involving 4,259 doctors in vocational training, provided insights into the factors influencing the career choice and workforce participation decisions of postgraduate doctors.

A workshop of stakeholders was convened to explore the workforce policy and vocational training implications of the findings of the AMWAC 2002 survey of doctors in vocational training. The workshop was held in Sydney on 3 November 2003, and attended by about 90 representatives of various stakeholder groups, including medical colleges, trainees, employers and government (see Appendix A for a list of participants). The workshop was facilitated by Lynette Glenndinning of PALM Management.

The workshop was designed around four themes:

- choice of discipline - determining factors;
- future practice location (State/Territory and urban/rural) - determining factors;
- vocational learning environment - effects on career decisions; and
- flexible training arrangements - full-time/part-time/job-share/hours of work.

This paper details the discussion and outcomes from the workshop. It is anticipated that the outcomes will guide future workforce policy initiatives in the vocational medical training area.

2. EXECUTIVE SUMMARY

The workshop identified many challenges with current vocational medical training arrangements. These included:

- the lack of structures and processes, including appropriate governance arrangements, to drive changes to training arrangements, including greater flexibility, and to ensure adequate communication among stakeholders;
- the location of training is out of step with community health needs. In particular, it is overly concentrated in urban centres and hospitals and there are disincentives to training in rural and other areas of workforce need; and
- the availability and quality of training is suffering because of the competing imperative of service provision, and the lack of adequate identified and quarantined funding and support for training.

Workshop participants suggested:

- Vocational training of medical practitioners should be recognised and addressed as an important national training and education issue, rather than just a health care issue.
- Training organisations should explore modularisation of training, to enable recognition of prior learning and greater transferability among disciplines. The education principles which underpin vocational training should be reviewed, and an adult learning model should be developed.
- A one-stop information resource is needed to assist trainees with more effective career planning.
- Establishment of a taskforce to develop a model and a vocabulary for flexibility in training. This would help ensure that all stakeholders shared the same understanding of what was meant by flexible training. The taskforce could set minimum benchmarks for flexibility, which would be adopted by service providers and colleges.
- The use of incentives to promote greater flexibility and mobility in training.
- The training environment must be expanded beyond public hospitals to include the private sector. More training should be based in the community and involve health care teams. Issues of funding have to be comprehensively addressed.
- Review the education principles which underpin vocational medical training to ensure they are based on an adult learning model.

3. OVERVIEW: CAREER DECISION-MAKING BY DOCTORS IN VOCATIONAL TRAINING

The workshop commenced with a scene setting presentation which recapped the main findings from the AMWAC Medical Careers Survey 2002. This presentation was provided by Mr John Ramsay, Chair, Australian Health Workforce Officials' Committee and Secretary, Department of Health and Human Services, Tasmania. (It should be noted the paper was delivered on behalf of AMWAC chair, Professor John Horvath, who was unable to attend the workshop.)

This survey is a first of its kind and provides a valuable snapshot of the plans, views and needs of doctors in vocational training.

Individual career decisions have a significant impact on the structure and the future of the medical workforce and are of interest to many.

The workshop outcomes will contribute to future policy for vocational training. The findings will be of interest to many, including trainees, hospitals, health departments and researchers.

We need to capitalise on the survey. There is a need for multifaceted strategies.

The outcomes of the workshop will provide important advice to AHMAC, AMWAC, and the colleges for formulating future action.

The four key themes of the workshop are:

- determining factors regarding choice of discipline;
- determining factors regarding future practice location;
- vocational learning environment; and
- training arrangements.

Determining factors regarding choice of discipline

Intrinsic include:

- interest in helping people;
- intellectual content;
- appraisal of own skills/aptitude;
- appraisal of own domestic circumstances; and
- perceived job security prospects.

Extrinsic include:

- opportunity to work flexible hours;
- atmosphere and work culture typical of discipline;
- work experience since graduation;
- opportunity for procedural work;
- hours of work typical of discipline; and
- influence of consultants and other mentors.

Determining factors regarding future practice location

- depends largely where educated and trained;
- the influence of rural background (four States and Territories had an above average proportion from rural backgrounds);
- 4% want to practise overseas;
- 82.6% prefer urban location; and
- 13.6% prefer rural or remote practice. This is more likely if they are of rural backgrounds themselves.

There are mixed views on compulsory rural training programs. Some thought it undesirable because of the effect on family life.

Vocational learning environment

Regarding supervision:

- 86% had a formal supervisor;
- 12% had no formal supervisor;
- 2% didn't know; and
- 66% satisfied with supervision.

Satisfying aspects of vocational learning environment:

- program quality and content;
- program structures and procedures;
- supportive relationships;
- supportive work environment;
- opportunities of program; and
- enjoyment.

Dissatisfying aspects of vocational learning environment:

- poor quality education, training etc;
- inadequate structures and procedures;
- non-supportive relationships with consultants; and
- rural training requirements.

Flexible training arrangements

Participation:

- 91% full time;
- 9% part time;
- less than 1% job share; and
- higher proportion of women part time.

Knowledge about part time option:

- 64% thought it an option;
- 17% said it was not an option; and
- 19% didn't know.

Working hours has emerged as a key issue of concern for medical professionals in recent years:

- 71% of doctors thought they worked about the right number of hours;
- 28% thought they worked too many hours; and
- 2% thought they worked too few hours.

Many comments at the end of the questionnaire expressed concern regarding working hours, and many wanted to work part-time.

We can use these findings to:

- better understand the needs, desires and wishes of junior doctors;
- improve workforce planning;
- design policy interventions;
- inform development of medical education;
- improve aspects of the environment; and
- communicate with consumers.

The challenges include:

- to interpret new and complex information;
- to identify critical issues to influence; and
- to shape agreed, and shared, directions.

4. KEY CHALLENGES ARISING FROM THE FINDINGS OF THE AMWAC REPORT

Workshop participants were asked to consider the key challenges arising from the findings of the AMWAC report, in line with the four themes of the workshop. The challenges highlighted in the group work and general discussion are summarised below.

4.1. *Future practice location*

- The difficulty of sustaining a rural workforce; how to replenish a diminishing rural workforce.
- How to be more innovative and flexible in training placements. The more standardisation means that individual requirements and centres' needs can be overlooked. How to be more responsive to individual needs in training in rural and urban areas?
- The idea that rural and remote training is seen as punishment needs to be removed; a need to destigmatise rural training.
- There should be more incentives for rural training for junior and senior doctors. How can rural practice be made more attractive? Even with financial incentives for rural training, this was not taken up by GP trainees. Financial incentives are necessary but not sufficient.

4.2. *Flexible training arrangements*

- There was general support from participants for health training arrangements.
- Flexibility around hours and interrupted training.
- Mismatch between desire and take-up of flexible arrangements.
- There is a tension between flexibility and service delivery.
- There is a need to address flexibility across training/career transferability. If someone has done some surgical training, can that prior learning be accredited by other training programs?
- Trainees think flexibility is very important but the training environment has three key players - hospitals, colleges and trainees - and there are gaps among those groups.
- Flexibility may increase costs but that is likely to be a short term problem.
- Improve integration between colleges and providers to improve flexibility.
- There is a need for communication/information re available options. Many trainees are not aware that flexible options are available.
- Lack of structures to run flexible training.
- Impacts on gender balance.
- Impacts on course duration.

There is a discordance between the number of trainees who say they want to do flexible training and those who are actually doing it. It is not to do with communication so much as the constraints under which people work. There will always be a gap between aspirations and what people want to do to meet their goals. Additionally, there is a certain tension between flexibility and the needs of a 24-hour, 7 day a week service.

There is a need to compromise between demands for flexibility and service provision. Often there is no apparent structure/experience in running flexible training. There is a need for

better development and dissemination of parameters for flexible training - a need for structured flexible training.

A seven-year undergraduate course plus flexible training means people are spending a very long time in training. Of course that also raises the question: is a seven-year medical education needed?

4.3. *Learning environment*

- Recognise service/training conflict. It is at the core of all the issues being discussed. The apprenticeship model is gone. There is less time for teaching; the registrars are supervising. Service providers need to recognise the teaching role of the unit and so do the staff. There seems to be a move away from the consultants teaching to consultants doing and disappearing, because of the changes in the structure of hospitals plus the increased throughput.
- How to take training and teaching away from the more specialised units to the general units is a very difficult problem.
- A need for protected teaching time.
- Better use of service as teaching and learning opportunities.
- Better utilise consultants as teachers. The lack of availability of consultants to supervise results in reduced competence of those in training programs. We need more consultants available to take seriously the role of teaching and training.
- Self responsibility. Trainees must take their own responsibility for their training. They should not expect to have it 'put on a plate'. It is a two way process.
- Timing of selection.
- Lack of supervision in rural areas. All of these issues are magnified in rural areas because of the lack of supervision, the clinical load and workforce shortages.
- Clarify learning requirements at each stage of training.
- Broaden training experience to reflect changes in practice settings and models of care - private and multidisciplinary/teamwork.
- Vertical integration of training.
- Train the trainer.

Some services are not good training experience. They are not training in the skills required for consultancy.

With the decreasing number of practical procedures in the public sector, there is a need to examine the need for training in the private sector. The challenge is to find a way to provide training in the private sector.

There is a need to provide a learning experience reflective of the future practice rather than the whole public or private debate.

With the shift from outpatients care to the private sector, what trainees see does not reflect reality. There is also the issue of should funding to follow the trainees. If this occurred it might also ensure that there is a better mix of learning environments in place and available.

Better practice is multidisciplinary care. That is the challenge for the future - it is about working in teams, whether in a public or private setting. The learning environment has to be multidisciplinary to prepare people for the way quality practice is moving. It is about practising with other health disciplines.

Simulation centres will face increasing demand. Training of the future may involve multidisciplinary team work management, simulation.

In a hospital, most of a trainees' training is done by the registrar. If trainees have studied a different course to them, registrars may not know what the changes to medical education have been.

There needs to be investment in consultants and upskilling them in training.

4.4. Choice of discipline

- Refine selection process/criteria.
- Better understand inability to recruit in specific disciplines. For example, in occupational medicine, trainees are working in industry and their opportunities often are limited by employers not having jobs for registrars.
- Better understand attractiveness of various disciplines.
- Provide more equitable remuneration.
- Delay choice.
- Improve access to role models, inside and outside teaching hospitals, female and rural role models. Most role models are based in teaching hospitals but most medicine is outside of teaching hospitals now. There is a need to provide more information about options outside the hospital setting. Most of the undergraduate curriculum is about acute care. But most of medicine is about chronic disease management. Research of medical students shows females find it difficult to find female role models who have managed to balance their work and life.
- Fear of litigation.
- Employer constraints.
- Reasonable working hours.
- Improve co-ordination and dialogue.
- Broaden influence on PGY1/2.
- Career planning/advice.

Are there still some opportunities to affect intrinsic factors through selection into medical school? Should there be further refinement of medical school selection?

How to achieve reasonable working hours in the face of shortages?

The only influence on PGY1 and PGY2 is the hospital influence. They are critical years and the total influence on young graduates is the hospital. This needs to be broadened.

There is no constructive career planning. People make choices for a variety of reasons and haphazardly hope there will be a job at the end of it. There is a need for a more structured approach.

Vocational trainees who go to the country are often going to places where the consultants are very busy and it is difficult to have a role model.

5. KEY CHANGES TO VOCATIONAL TRAINING AND/OR WORKFORCE POLICY THAT NEED TO BE CONSIDERED IN MEETING THE KEY CHALLENGES

Participants were asked to identify key changes to vocational training and/or workforce policy that need to be considered in meeting the key challenges. This section of the program started with a discussants' thoughts on the issue.

Discussant, Dr Jill Sewell, Chair National Institute of Clinical Studies and Deputy President Royal Australasian College of Physicians

Most of the discussion this morning has been about the individual needs of trainees. They go through a learning pathway. One has to think about whether individual trainees are perceiving themselves as the passive recipients of training by employers, institutions, and Colleges or whether they are making a proper career choice in an adult learning environment. In other words, where is the responsibility of the individual for finding out about appropriate training?

There has been very little discussion of the health needs of the Australian community. We know quite a lot about the needs and the prediction of the future needs. We have to consider the needs of the community versus our individual needs. We have to keep our responsibility to the community in the back of our minds while developing better structured, flexible career pathways. It's very hard to shift away from the status quo and the assumed current paradigm.

We have to think about a whole different way of delivering health care. There is an international medical, nursing and allied health workforce shortage. We have to think about whether there is a different way of delivering health care in a way which empowers individuals to take better care of themselves. In other words, don't just think about current paradigms.

The other issue which has not come up this morning is that there are a lot of differences between the way men and women practise medicine and make career choices. Plus there are many things which are the same. My question is, does this matter? Is there any value to understanding enough about those differences to reduce the differences? Should we be trying to reduce the gender divide? It is just a question I put to you. I am not sure what the answer is.

And are there other issues apart from gender to consider?

Plus a warning: we have a 1.5cm thick report, which provides a first snapshot. It gives us very important information, but not everything is known. We need to use the information wisely and well but integrate it with other information sources. In other words, this is a warning against making radical changes based on one snapshot.

5.1 What are the changes needed to make rural training more attractive?

- Communication issues. An awareness of what needs to change and what makes rural training attractive. Many trainee decisions are made informally. There is a need for more objective, systematic information.
- Personal issues, including incentives such as financial, travel, and accommodation assistance, as well as personal supports. Packages should be attractive and individualised.
- Professional issues, including infrastructure, professional support networks, teleconferencing etc, as well as clinical experience.
- Insufficient information is available to decide whether rural training should be compulsory. There is some evidence that in general practice it does not work but that it does in surgical disciplines. How good is compulsion as a lever of change?

There is a difference between what makes rural training attractive versus what makes a rural career attractive.

There is nothing that certifies the additional skills that the rural medical practitioner obtains outside current training opportunities. That is a component of the failure to provide rural medical practitioners.

The importance of compulsion should not be underestimated. If not for the ability to access provider numbers in areas of need, the rural workforce would be diminished.

5.2 How to ensure training is flexible enough to meet individual and community needs?

- Change the perception of system and trainees regarding what is valued in the trainees' experience.
- Focus on the goals of the intern year, to broaden experience to align it with community needs.
- Delay the need to make a choice about future career. The pressure currently is to make a choice upon leaving medical school or in the following two years, when the choice may not be based on the needs of the community or the individual.
- Widen the range of choices in the intern year with career and vocational counselling.
- Provider number legislation increases the need to make the choice. There are many factors - not just the way Colleges structure their programs or the service imperatives of hospitals - which contribute to pressures to make a career choice.

Interns do not obtain the public health perspective about what the needs of the community are while working in hospitals. There is a need for a population/public health perspective. The range of choice in the intern year needs to be broadened.

There needs to be debate around the notion that taking longer and doing more, ie. is quantity and frequency, is better. There also needs to be greater transferability between careers pathways.

5.3 What changes are needed to better meet service and trainee needs?

- There is a need for structured learning for trainees.
- Health providers need to value flexibility in training. Many hospitals may need to employ more doctors in order to provide this.
- Minimum standards should be set and measured.
- Australian health care agreements should ensure funding is set aside for training. There needs to be a greater investment in training, and to measure and systemise it, to a greater extent than currently happens.

5.4 What changes are needed to enable flexible careers?

- Better recognition of prior learning and of the generic elements of training across specialties.
- Better transferability, with the development of more common elements in training.
- Greater career flexibility, including more flexible community training.
- Changed funding arrangements. The federal/states split makes community training difficult because it is not part of the funding of community care.
- Legislative changes to make the system more flexible.
- Role models and information need to be available and accessible.

5.5 What changes are needed to ensure training is appropriate for the future?

- Training must be located where the patients are.
- The funding model needs changing, so trainees can see private patients.
- Development of capacity for training in private practices, as already happens in general practice.
- Changes to outpatients arrangements.
- Development of fast track options.
- Greater use of technicians and allied health professionals.

5.6 What changes are needed to better integrate learning?

- Identify similarities in content in training areas, leading to multidisciplinary training modules. This may also have the effect of fostering a change in attitudes across the disciplines to reduce competition for 'who gets which trainees'.
- Upgrade accreditation of medical schools to ensure they are meeting the future needs.
- Identify educators who bridge the learning environment.
- Train the educators. Being a good clinician does not necessarily make a good educator. Part of that training could be multidisciplinary.

5.7 What changes are needed to ensure informed choice?

- Information to all trainees must be up to date.
- Hold a careers exhibition where Colleges can hold training days at the hospital to discuss options.
- Undergraduate role modelling, with students attached to a consultant for eight to ten weeks.
- Colleges should look at mentoring and protected teaching time for the PGY1 and 2 training years. It also needs to be recognised that they are used to staff the hospitals.

- Those who have made their choices by the end of medical school should be able to go into the specialty.
- Colleges should have a current register of specialist training posts to help provide better information and communication across the system.

5.8 What changes are needed to shape decisions to better meet need?

- Community needs should be better determined and workforce studies kept up to date.
- Reasons why some disciplines are not attracting the numbers of doctors need to be examined.
- There is a need for a market analysis, and debate about whether this should be a free market or centrally controlled.

5.9 What changes are needed to ensure effective communication and information?

- There is not enough systematic dialogue among AMWAC, the colleges, service providers, the Australian government and the State/Territory governments.
- Work practices may need to change in view of the move to multidisciplinary care. Non medical practitioners will be doing some of what doctors now do; there is a need for a paradigm shift.
- A National Board of Studies may be needed to change governance arrangements.
- A national training package should be developed, which takes a more centralised approach.

Summary of what changes are needed overall

1. Develop national arrangements to ensure effective governance of medical workforce planning and preparation. This would involve the Australian Government and States, AMC, Colleges, universities and hospitals.
2. Build capacity for an integrated and flexible approach to education and training. There should be flexibility across disciplines and within training, changes to the intern year, vertical integration, development of trainers' capacity, and national training packages.
3. Address system constraints to flexibility, including work practices, employer constraints, service delivery tensions, funding models/legislation.
4. Inform and communicate across the system. Develop an information base regarding patterns of choice; develop and disseminate to trainees.
5. Support rural training through targeted incentives, personal and professional support, and training for rural practice. There should be a reassessment of compulsion policies.

The themes of the suggested changes are:

- good governance; making sure the players nationally communicate effectively with each other to steer the process;
- flexible capacity, across disciplines and vertical integration;
- capacity of trainers and intern year;
- fixing system constraints;

- information and communication; and
- rural training.

6. FUTURE DIRECTIONS

This section of the workshop commenced with a series of 'thought starter' presentations from key stakeholders, drawn from the university, vocational training, hospital and rural sectors. The main points from each presentation are summarised below.

Professor Bruce Dowton, Dean of Medicine, University of NSW, Chair of the Committee of Deans of Australian Medical Schools

There is good evidence that sustainable innovation does not easily come out of organisations doing things the way they have always done things. It is about change and seeing things in new ways.

The pipeline of medical students is very important but only a very small part of the continuum of providing a sustainable medical workforce.

Students have a much greater desire for flexibility. It is much more market driven - students are more demanding of what they want. Medical schools and postgraduate training environments need to do more work.

We have seen a number of medical schools move to an outcomes-based approach - what do they want their graduates to be? There is also a significant untapped opportunity to obtain more integration of true expertise, like adult learning theory, into disciplines.

Plus there is a need for funding integration. The Commonwealth/State divide is a significant issue.

We need to hold true to the reality that we have moved into a global market place. These issues are being tackled elsewhere and raise issues regarding our responsibility to the underdeveloped world and stealing practitioners out of those environments.

Regarding flexibility, it is not only an issue for the program design for medical trainees. We need to be thinking about multiprofessional learning environments, as well as how real and sustainable workplace reform could help address workforce shortages.

There is a need for integrated government systems which articulate well up and down and across the education sector.

One of the major issues is the capacity for the medical schools to ensure proper supervision and training as training becomes more dispersed into community based systems.

Regarding information and communication, we all have to strive to improve how we communicate within our particular part of the sector and across the sector.

Sustainability is a real issue for all in the medical workforce area. Sustainable innovation is well shown in general not to occur out of existing organisational structures doing what they have always done. We need to think of new ways of doing things.

Dr Peter Kennedy, Central Sydney Area Health Service

We didn't talk about funding this morning and that has to be explicit. We can not do this without adequate resourcing. There is no commitment from the Federal or State governments to do it. There is no use telling hospitals to train more doctors in this area unless we are funded to do it. Innovation requires funding and must go beyond cost shifting.

Dr Debra Graves, Royal College of Pathologists of Australasia

One of the things not brought up a lot this morning is that we are talking about a finite number of students and we are all trying to get them into our area. We need a larger pool to start off with to address workforce shortages.

We need a better government structure and funding for training and not just for the positions. Support is also needed for the training. Colleges can collaborate better with health departments.

Regarding looking for innovative ways to get career information out to trainees - there is a need for better co-ordination. At present we have to go to nine different jurisdictions.

Professor John Humphreys, Monash University School of Rural Health

We need to dispel some of the myths regarding rural and remote. One gets the sense that rural is somehow 'different' - implicit is that it is somehow less desirable.

Regarding the inability to attract GPs into rural and remote areas, we have not adequately addressed what we need to do to make it attractive. We need to maximise the 'pull' factors which may attract people, as well as the 'push' factors which may be appropriate.

While this AMWAC document identifies a lot of the issues, we do not know at what point to put leverage into the system and to maximise those things that will work well and to minimise potential barriers.

Factors which work are:

1. predisposing factors, such as the aspirations or interests of people moving to take up rural practice.
2. enabling factors. Where training programs have a rural mission, there's a great take up of rural practice.
3. reinforcing factors, such as mentoring to break down isolation. We need a systemic approach. Initiatives and pilots are too often a one-off.

We will not solve the medical workforce problem unless there's a system approach, as well as addressing non medical factors such as lack of infrastructure.

We need to give great play to the less obvious barriers and deterrents. The training environment, such as consultants and hospitals, may inadvertently promote those ideas we want to dispel - for example, by asking, 'why do you want to go to a rural environment?'

The solution involves a symbiosis of urban and rural and remote.

Facilitator: So where can we get traction?

Dr Peter Kennedy: We have to tackle the length of training. Some of the college courses are getting longer rather than shorter. Should we do it more intensively over a shorter period? That would have service implications and cost, but we need to look at it.

Multidisciplinary team work is becoming much more important. We need to look at how we manage training. What are the rules of supervision, who pays for indemnity and for specialists' time involved in training in private rooms? That needs to be formalised with accreditation and standards.

Dr Debra Graves: Regarding collaboration between colleges and universities, we asked trainees whether five years was the right time. About 20% felt it was too short, and about 70% thought it about right. Not many felt it should be shorter.

Professor Bruce Dowton: If one looks at the five major stakeholders involved - colleges, PGMs, universities, State governments, and the Commonwealth - getting any three of them involved would be enough to drive changes, especially if one was a fund holder like government. Even just one of the big states getting involved would drive change.

Facilitator: Does the panel have any 'tips and traps' for the groups regarding moving forward?

Professor Bruce Dowton: If we ignore robust governance, we do it at our own peril.

Dr Debra Graves: Imposing change won't work.

Professor John Humphreys: The need for accountability.

Dr Peter Kennedy: Imposing change is the biggest issue. Hospitals and GPs will have to do the changes at the coalface.

Comment: I do worry about when things are difficult that we introduce another layer into governance.

Comment: In the UK, there's a new acronym - The Postgraduate Medical Education Training Board. Thirteen of the 25 board members are medical practitioners. It is chaired by a former Rolls Royce human resources executives. It aims to address many of the issues being raised here today. Do we need this?

Dr Peter Kennedy: We don't need too much bureaucracy. Colleges do training quite well. We have very good training of our specialists. If we make changes, we have to ensure the quality of our training doesn't suffer. I wouldn't change the Colleges having control of training. I don't think the answer is to turn everything upside down.

Professor Bruce Dowton: The governance question is, how can we ensure governance is linked to accountability? There's not much evidence of a shared framework of governance and accountability.

7. A WAY FORWARD

This section summarises the suggestions proposed by workshop participants in relation to the some of the challenges facing vocational medical training.

7.1 General

- Establish a National Board of Studies to facilitate implementation of workforce and education initiatives and to oversee all education, workforce and training issues. Others thought it better to increase collaboration among stakeholders as much of the structure is already there (ie Committee of Presidents of Medical Colleges, Medical Training Review Panel), that it just has to be used better.

7.2 Choice of discipline

- Modularise training, strengthen cross recognition between colleges and PMC and transfer opportunities.
- Recognition of prior learning: identify commonalities; there should be an undifferentiated first year of vocational training; training should be portable and mobile across disciplines (the colleges and PMC should pick this up - look at what is common across their disciplines and make this happen). Some colleges already have some cross training. The College of Medical Administrators is doing some work in this area.
- Develop career information planning portal - this should be electronic, up to date, and easily accessible.

7.3 Practice location

- Develop individual tailored package of rural incentives. Disincentives to rural training should be overcome without the present compulsion-based approaches.
- Develop re-entry pathways and rotation for rural-urban so that rural does not mean a career-long commitment.
- Identify workforce shortages and develop strategies specific to particular issues.

7.4 Training environment

- Invest in education and training. Make the business case that this is an industry capability and education, rather than a health, issue. New funding arrangements are needed. National/state co-ordination is required, and training should be outside traditional models. Training dollars must be divorced from the health dollar. Money should be quarantined to fund it.
- Shift training to community and focus training on health care teams.
- Redesign the intern year. Pilot it in one State/Territory.
- Work practice reform, including reform the ways junior medical staff are used in hospitals.

7.5 Flexibility of training

- Convene group to adopt minimum benchmarks for flexibility, such as 15% of trainees are undertaking part time training, and evaluate the impact. Flexibility needs to be defined and measured. The taskforce could include the Australian Medical Association, industry,

trainees, states/territories, hospitals, colleges and trainee providers. The minimum benchmark should be adopted by hospitals and colleges.

- Develop increased flexibility through competition, with alternative providers and pathways to fellowship. Much of the current training is by transnational providers which can be resistant to change. Open up the Colleges to competition as happened with general practice. Accreditation and training delivery should not be with one provider.
- Increase co-ordination among hospitals. For example, part time trainees are often isolated and it may work better if two or three hospitals collaborated regarding part time trainees.
- All health providers need to acknowledge the real additional cost of training. The principle is supported but not necessarily with the particular mechanism. Funding for training outside the traditional models should be provided. Most of it is now based in the hospital system. Funding is needed to help the trainers to be better trained and to have the time for training.

8. OUTCOMES AND ACTIONS

To close the workshop, Dr Simon Willcock (New South Wales Postgraduate Medical Council), was asked to provide a summary of the outcomes of the discussion.

I will focus initially on the issues and processes where there is consensus, and in the context of there being a medical workforce shortage for the foreseeable future.

Areas of consensus

1. There are disincentives to training in areas of medical workforce need (I am deliberately not using the word rural). There is a need for packaging of incentives and strategies for flexibility and mobility.
2. We need to convene a group which will develop a model and a vocabulary for flexibility in training. Flexibility means different things to different people. including the AMA, Colleges, trainees, providers.
3. Recognition of prior learning and modularisation needs to be explored with a view to identifying and removing barriers and making processes more generic. The current rigid silo system no longer services community needs.
4. This is an important national training and education issue - not just a health care issue.
5. Funding is needed. A case must be made for investment at a national resource capability level rather than a health service reform issue.

Expansion of the training environment to include the private sector is essential. Issues of funding (Commonwealth versus State/Territory) and indemnity have to be addressed. (They are currently being addressed in part by a separate AHMAC working party).

6. We need a one stop information resource to allow for more effective career planning.
7. We need to review the education principles which underpin vocational training. We need an adult learning model.

Other issues to consider:

1. A national governance body or Board of Studies is needed to action change to vocational medical training and evaluate initiatives. It can be lean. Without this, many of the issues that have discussed may not go ahead.
2. Quarantined training dollars are needed. Quarantining the education dollar to cut out the hospital administrator will disempower a significant stakeholder. An alternative is to allow the States/Territories to allocate dollars and training places. One alternative is to allow States/Territories more control of the dollars in training.

3. Work practice reform, starting with the intern year. If we do not tackle it, we will still be applying band aids.

4. Alternative pathways to accreditation, as happened with GPs.

5. Is this all really a problem? The survey says that two-thirds of registrars are reasonably happy. But I think the problem is much greater than this report indicates. Distress rates are probably far higher than this study suggests because of its low response rate. It is the non responders who are really stressed.

Appendix A: Workshop Participants

Dr	Ion	Alexander	Royal Australasian College of Physicians
Dr	Max	Alexander	Australian Capital Territory Health
Dr	Linda	Aykut	Australian and New Zealand College of Anaesthetists
Dr	Robert	Bain	Australian Medical Association
Ms	Katy	Balmacks	Australian Government Department of Health and Ageing
Ms	Margaret	Banks	New South Wales Health
Dr	Linda	Black	Adelaide to Outback GP Training Program
Dr	Lawrie	Bott	Royal College of Pathologists of Australasia
Dr	Roger	Boyd	Royal Australasian College of Medical Administrators
Ms	Danielle	Brown	Committee of Deans of Australian Medical Schools
Dr	Matthew	Bryant	General Practice Registrars Association
Professor	Allan	Carmichael	Australian Medical Workforce Advisory Committee
Ms	Claudia	Casson	Australasian College of Dermatologists
Dr	Virgil	Chan	Royal Australian and New Zealand College of Radiologists
Dr	Deryck	Charters	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Dr	Jack	Chen	University of New South Wales
Dr	Bill	Coote	General Practice Education and Training
Dr	Allan	Cormack	Royal Australian and New Zealand College of Radiologists
Dr	Kate	Cross	Royal Australasian College of Surgeons
Ms	Justine	Curnow	National Health Workforce Secretariat
Professor	Geoffrey	Dahlenburg	Council for Early Postgraduate Training in South Australia
Professor	Trish	Davidson	Royal Australasian College of Surgeons
Mr	Brett	Dee	National Health Workforce Secretariat
Professor	Hugh	Dickson	Australasian Faculty of Rehabilitation Medicine
Professor	Bruce	Downton	Faculty of Medicine, University of New South Wales
Dr	Andrew	Ellis	Association of Psychiatrists in Training
Ms	Sharon	Flynn	Coast City Country Training
Dr	Elizabeth	Fugaccia	Joint Faculty of Intensive Care Medicine, Concord Hospital
Dr	Kalpesh	Gandhi	Joint Faculty of Intensive Care Medicine, Westmead Hospital
Professor	Paul	Gatenby	Faculty of Medicine, Australian National University
Mr	Paul	Gavel	National Health Workforce Secretariat
Dr	Kieran	Gleeson	New South Wales Health
Dr	Debra	Graves	Royal College of Pathologists of Australasia
Professor	John	Humphreys	Monash University School of Rural Health
Dr	Suzanne	Huxley	Health Advisory Unit, Queensland Health
Dr	Shaylee	Iles	Australian Medical Association Doctors In Training
Dr	Brian	Jardine	Public Service Association (New South Wales)
Dr	Nathan	Johns	Australasian Faculty of Rehabilitation Medicine
Dr	Peter	Kennedy	Central Sydney Area Health Service
Dr	Greg	Keogh	Postgraduate Medical Council of New South Wales
Dr	Peter	Keppel	Rural Doctors Association Australia
Dr	Rita	Kirby	Royal Australasian College of Surgeons
Dr	Eng-Siew	Koh	Westmead/Nepean Hospitals Radiation Oncology Network
Dr	Alison	Latta	New South Wales Health
Dr	Caroline	Laurence	Adelaide to Outback GP Training Program
Dr	Noni	Lewis	Royal Australasian College of Ophthalmologists

Dr	Dennis	Lewis-Enright	Australasian Faculty of Occupational Medicine
Mr	Paul	Magnus	Australian Institute of Health and Welfare
Dr	Mary	Mahoney	Australian Medical Workforce Advisory Committee
Dr	Liz	Marles	General Practice Registrars Association
Dr	Wendy	Marshman	Royal Australian and New Zealand College of Ophthalmologists
Dr	Frederic	McConnel	Northern Territory Department of Health & Community Services
Ms	Kirsty	McEwin	NSW Rural Doctors Network
Dr	Greg	McMeel	Greater Green Triangle GP Education and Training Inc.
Professor	Kichu	Nair	Royal Australasian College of Physicians
Ms	Elizabeth	O'Brien	National Health Workforce Secretariat
Dr	Natalie	Old	Royal Australian College of General Practitioners
Dr	Kurosh	Parsi	Australasian College of Dermatologists
Professor	Michael	Peek	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Ms	Monica	Pflaum	Australian Government Department of Health and Ageing
Professor	Garry	Phillips	Australian and New Zealand College of Anaesthetists
Ms	Lise	Pittman	Victorian Department of Human Services
Mr	Edmund	Poliness	General Practice Registrars Association
Ms	Jantze	Purton	New South Wales Health
Mr	John	Ramsay	Australian Health Workforce Officials Committee
Dr	Janet	Roddy	Postgraduate Medical Council of Western Australia
Dr	Peter	Roeser	Confederation of Postgraduate Medical Education Councils
Mr	Mick	Saunders	Australian Medical Association
Ms	Joan	Scott	Australian Capital Territory Health
Dr	Jill	Sewell	Royal Australasian College of Physicians
Dr	Antonia	Shand	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Dr	Vicki	Sheedy	Australian College of Rural and Remote Medicine
Dr	Andrew	Singer	Australian College for Emergency Medicine
Dr	Becky	Siu	Royal Australasian College of Physicians
Ms	Leonie	Smith	Australian Government Department of Health and Ageing
Assoc. Prof.	Neil	Spike	Monash University
Dr	Edward	Stachowski	Joint Faculty of Intensive Care Medicine, Westmead Hospital
Dr	Jonny	Taitz	Royal Australasian College of Physicians
Dr	Dora	Tamaras	Royal Australasian College of Physicians
Dr	Lloyd	Toft	Australian Medical Workforce Advisory Committee
Dr	Helen	Tolhurst	University of Newcastle
Ms	Helen	Townley	Australian Health Workforce Officials Committee
Ms	Ruth	Travis	Australian Government Department of Health and Ageing
Dr	Sandra	Turner	Royal Australian and New Zealand College of Radiologists
Dr	Kavita	Varshney	Australasian College for Emergency Medicine
Professor	Alan	Walker	Northern Territory Postgraduate Medical Council
Dr	Ian	Watts	Royal Australian College of General Practitioners
Dr	Simon	Willcock	New South Wales Postgraduate Medical Council
Dr	Sharron	Wiley	General Practice Registrars Association
Dr	Jeannette	Young	Australian Medical Workforce Advisory Committee
