Challenges and change in medical training: the Australian Curriculum Framework for Junior Doctors

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A giant step forward, but more needs to be done

To have lived through a revolution, to have seen a new birth of science, a new dispensation of health, reorganized medical schools, remodeled hospitals, a new outlook for humanity, is not given to every generation.[1]

An enduring feature of modern medicine is the constancy of challenges and change — and no more so than in medical education and training. In the 1980s and 90s, the Australian medical workforce was deemed to be adequate for the requirements of health services and the community,[2] and for more than 20 years there was no political pressure to expand the capacity of our medical schools.[3,4] More recently, Australia, along with the rest of the world, has found itself in the grip of a serious medical workforce shortage. This has moved the Australian Government to establish six new medical schools since 2004, in addition to the 11 existing schools. A further five are in the pipeline.[5] With this unprecedented expansion, the number of medical graduates is set to rise from around 1600 in 2005 to about 3000 in 2012.[5,6] In short, in less than a decade, the number of medical schools in Australia — and their graduate output — will have doubled.

Despite the claim that with medical school plurality comes diversity,[7] the purpose of our medical schools is decidedly uniform: to produce a graduate who has the attributes and commitment for lifelong learning and a solid foundation on which to build a clinical and professional career. The Australian Medical Council details this foundation in medical knowledge and understanding, skills, and professional behaviour, and notes: "The goal of medical education is to develop junior doctors who possess attributes that will ensure that they are initially competent to practise safely and effectively as interns in Australia or New Zealand, and that they have an appropriate foundation for lifelong learning and for further training in any branch of medicine."[8]

Medical education is a continuum from medical school to independent practice, but the prevocational years (PGY1 and PGY2) interposed between undergraduate and vocational training are crucial in the quest for good medical practice and good doctors. And herein lies the rub — the prevocational years have been labelled as a lost opportunity for medical education.[9] The factors responsible for this are many and include the apprenticeship nature of training;[10-12] an ill-defined curriculum;[10] training by time-poor and variably competent teachers;[10] variable teacher training;[13] the clash between the priorities of service delivery and education;[10,12] and variable resourcing of teachers, program supervisors, and the state or territory postgraduate medical education councils.[12,14] But at the core of the lost opportunity has been the lack of a relevant and rigorous national curriculum.

The supplement "Australian Curriculum Framework for Junior Doctors" published with this issue of the Journal is a giant step forward in bringing much-needed national guidance for Australian prevocational medical training, and celebrates the launching of the Framework by the Confederation of Postgraduate Medical Education Councils in October 2006. The Framework is the outcome of wide consultation with relevant stakeholders and is built on initiatives pioneered by the Postgraduate Medical Education Councils of New South Wales (now part of the NSW Institute of Medical Education and Training), South Australia and Western Australia, and was funded by the Medical Training Review Panel of the Australian Government Department of Health and Ageing. It also draws from the experience of the recently introduced "Modernising Medical Careers" Foundation Programme in the United Kingdom[15] and the Royal College of Physicians and Surgeons of Canada's CanMEDS 2000 Project.[16] The Framework, in essence, is a template for education and assessment of performance of junior doctors in the major areas of clinical management, communication, and professionalism (see Box).

The Confederation of Postgraduate Medical Education Councils and other relevant players are to be congratulated for making this defining document a reality. It shows what can be achieved with purposeful leadership and effective communication between key stakeholders. But there is more to do! The Framework has to be implemented Australia-wide in hospitals and in general practice. This will require commitment and support from the federal, state and territory departments of health, public hospitals, and general practice. Without this, nothing will change. These agencies need to acknowledge that investment in prevocational medical training now will yield dividends in health care safety and quality in the future. Prevocational education must be a separate entity, not another health service add-on.

The Australian Curriculum Framework for Junior Doctors[12,17]

- The Framework is an educational template that identifies the core competencies and capabilities necessary to provide quality health care. It will enable individual doctors to assess their education and training needs.
- It outlines the general knowledge, skills and behaviour that prevocational doctors should acquire, regardless of their planned specialisation or training location.
- It bridges undergraduate curricula and college training requirements, and is intended to assist education providers, clinical teachers and employers to provide a structured and planned program of education for junior doctors.
- It is built around three learning areas — Clinical Management, Communication, and Professionalism — which are divided into varying numbers of categories and topics.
- Each category comprises a number of learning topics, each of which details the associated capabilities expected.
- It is envisaged that learning and assessment resources will be made available to support each learning topic. ◆

The need to assess the utility and impact of the Framework is self-evident: will it make a difference? Answers to this vital question will require the elaboration of discerning and measurable outcomes and processes for assessment. The article by Grant in the supplement (*page S9*) outlining initial experience in the UK with Foundation Years 1 and 2 of the Modernising Medical Careers Programme (the equivalent of our PGY1 and PGY2) provides a valuable insight into what *not* to do: introduce a detailed determination of clinical competence based on multiple observed activities, in the face of insufficient resources and poorly informed and prepared participants.[18] Edmonds and Everett (*page S20*) outline the views of junior medical officers, registrars, and directors of clinical training on the Framework.[19] Junior doctors caution against failing to include affected stakeholders in its implementation, request that training positions be accredited, and believe that the Framework should be a promoter of teaching and not a barrier to vocational training or another checklist to complete.[12] Registrars and directors of clinical training believe that the Framework will add value and resources to current training systems, and improve support for international medical graduates entering the workforce.

We continually hear the descriptors "coordinated", "integrated", "assessment" and "accredited" applied to the medical training continuum, and to the casual observer it does appear to be a linked and orderly process. But with the expansion of our medical schools, current cracks in the continuum will become wide gaps. Questions now asked *sotto voce* will become *fortissimo*; questions such as:

- Will the medical education and training infrastructure be able to cope with increasing throughput? Despite teaching alternatives such as simulation, the experience garnered by extensive clinical exposure still remains crucial in medical training.[9]
- What are the core competencies of the new medical graduate? How are these to be tested?
- Should undergraduate and prevocational medical education and training be outcome-focused?
- With differing medical school curricula and assessments, should there be a common yardstick? Is a national qualifying examination overdue?
- Are current postgraduate training programs too long and inflexible?
- Should there be early vocational streaming?
- Should there be common basic training modules that are transferable between colleges?
- Should there be part-time and flexible tracks to cater for the lifestyle expectations of modern doctors, especially younger doctors and women?
- Should there be different competence ceilings for differing levels of specialist training?

And there are more.

Several experts have poignantly drawn attention to how the Australian medical training sector is fragmented and plagued by limited collaboration and coordination between relevant groups.[11,14] Underscoring this is the current situation: the medical schools have their representative body, Medical Deans Australia and New Zealand; the clinical colleges have an overarching body in the Committee of Presidents of Medical Colleges; and the postgraduate medical councils have the Confederation of Postgraduate Medical Education Councils. But despite their good intentions, all are virtual silos with limited interaction beyond their immediate spheres of interest. Is it not time that this insularity is broken down? If not, the drive for reform of Australian medical education and training may come from outside the profession in the form of an overarching government-regulated body.[20] As a profession, do we really want this?

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