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Ms Theanne Walters

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Dear Theanne,

Thank you for inviting the AMA to comment on the proposed scope of the review of the Standards for Assessment and Accreditation of Primary Medical Programs (the review) by the Australian Medical Council (AMC).

The AMA is broadly supportive of the approach to, and proposed scope of, the review. A great deal has changed in the medical education and training environment since the last iteration of the standards and it is timely that these are reflected in a revised standard. In this respect the AMA would like to see the following aspects attended to as part of the review.

1. Public benefit test

Australia is now graduating record numbers of medical students, well above the OECD average. Health workforce modelling projects a likely surplus of medical practitioners and highlights that the medical workforce challenges faced by Australia essentially fall into the following categories:

- Insufficient postgraduate training places;
- Workforce maldistribution; and
- Shortages in particular specialty areas.

We know there is immense pressure on the medical training pipeline and intense competition for resources. Unfortunately, universities continue to ignore these realities and pursue the establishment of new medical schools.

Current AMC standards have too narrow a focus and ignore the broader policy and resource implications that applications for the accreditation of a new medical school inevitably involve. For example, the approval of the Macquarie University Medical School, in the context of current medical workforce challenges, undermines the credibility of the AMC and the role it ought to be playing in delivering a high quality and sustainable medical workforce.

The AMA proposes a new standard that would require applications for a new medical school to demonstrate a net public benefit, taking into account factors such as:

- Medical workforce projections;
- Existing availability of places;
- Impact on existing medical programs;
- Impact on existing teaching resources, taking into undergraduate, prevocational and specialist training;
- Availability of prevocational and vocational training places.

2. Student wellbeing

The AMA strongly supports strengthening the standards to address student wellbeing and wellness, noting that this is a complex area, relevant across many aspects of the standards. We have an opportunity to make sure the revised standards promote student wellbeing in a practical and considered way. The impact of bullying and harassment, and sexual harassment, on health and wellbeing, education and training and careers must also be addressed.

Not only do students need to learn how to be a health advocate for individuals and communities, they need learn how to be an advocate for themselves and their colleagues, and to be equipped with the requisite skill set to do so (Domain 3). Students need to know how to manage high workloads and pressured situations, how to put in place strategies to manage stress, depression and anxiety, fatigue and burnout, how to recognise when they or their colleagues need help, and where and how to access that help early on. They need to have confidence in the process, and that seeking help will not jeopardise their career (Domain 4). Programs in medical school and during early postgraduate medical training that encourage psychological health awareness, decrease stigma and facilitate help-seeking behaviour should be included as part of the curriculum (Standard 3).

Resilience training is important but it is more than that. Medical students, doctors in training and doctors tell us that in addition to equipping themselves with the appropriate skill set to manage their health and wellbeing, the system also needs to support them to achieve that. Accreditation standards have a vital role to play in ensuring that education providers and clinical learning environments provide a physically and psychologically safe and healthy environment to learn in. This means demonstrating that policies and practices are in place to ensure that clinical learning environments provide for safe working hours, access to meal breaks, appropriate supervision, and dedicated time to learn. It means making sure that learning environment genuinely consult and engage with students and supervisors about the learning environment. It means that students and supervisors need ongoing and regular training in performance management, giving and receiving feedback, having difficult conversations, manage complaints, learning how to fail, how to identify, deal with and report discrimination, bullying and harassment, and how to identify our own unconscious biases (Standard 4).

It follows that education providers and clinical learning environments need to have transparent, fair and timely processes in place for assessment and feedback, and that students and staff are clear about what assessment standards mean, and how they should be met. Where concerns about performance/competence become apparent, students must be informed without delay and given the opportunity to correct their performance, with access to robust reconsideration, review and appeals, and complaints handling processes if required. (Standard 5). These processes must be validated as professional, independent, confidential, and timely, and must result in an outcome. In relation to bullying and harassment, they must provide students with a safe place to bring forward complaints – free of shame, stigma or fear of repercussions. Further, monitoring and evaluation

processes should include reporting on review, appeals and complaints handling processes in a similar fashion to that done by the Royal Australian College of Surgeons.[1]

Having said that, it is also important the education providers are not afraid to fail students who do not meet the standards for safe and independent medical practice, and that systems are in place to provide careers counselling as required.

3. **Social media and professionalism**

The AMA would like the review to consider how the curriculum can best equip medical students with the knowledge and skills to use social media appropriately and professionally, including in clinical practice. Despite there being a raft of guidelines for the medical profession about how to use social media responsibly, and an increasingly technologically savvy cohort of doctors emerging from medical school, the evidence suggests that unprofessional and inappropriate use is highly prevalent.

A survey of medical students in 2015[2] found that social media use was nearly universal. The most commonly used platforms sere Facebook (99.4%), followed by YouTube (96.9%) and blogging platforms (45.3%). The survey also revealed that posting of unprofessional content on social media was highly prevalent despite understanding that this might be considered inappropriate, and despite awareness of professionalism guidelines. It recommended that medical educators consider approaches to this problem that involve more than simply providing guidelines or policies, and that students should be regularly prompted to evaluate and moderate their own online behaviour (Domain 4 & Standard 3).

4. International Students

The AMA would also like the standards to require education providers to be to more upfront and transparent about the about the medical workforce situation in Australia to prospective full fee paying international medical students (IMS), and their likelihood of accessing an internship in Australia following graduation (Standard 7).

The AMA continues to receive anecdotal reports that there are IMS who still believe they can access an internship to complete their training in Australia when this may not be the case. This is despite previous advice from Medical Deans Australia and New Zealand (MDANZ) that medical schools were providing information to prospective students about the limited availability of intern places.

The medical training pipeline is now under immense pressure and workforce modelling shows an emerging oversupply of medical practitioners. While many international medical students might wish to remain in Australia, the vast majority will be unable to complete their medical internship here and receive full medical registration.

The AMA strongly believes that medical schools must provide prospective IMS with timely, accurate and unequivocal information about the current medical workforce situation, particularly the limited availability of medical internships. It is unfair that they are potentially being encouraged to study in Australia with the false hope of an intern place.

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[1] Royal Australasian College of Surgeons 2016 Progress Report Building Respect, Improving Patient Safety https://www.surgeons.org/media/media-releases/racs-publishes-progress-report-on-bullying/

[2] Unprofessional behaviour on social media by medical students. Christopher J Barlow, Stewart Morrison, Hugh ON Stephens, Emily Jenkins, Michael J Bailey and David Pilcher. Med J Aust 2015; 203 (11): 439. || doi: 10.5694/mja15.00272 https://www.mja.com.au/journal/2015/203/11/unprofessional-behaviour-social-media-medical-students

International medical students deserve to be given sufficient information to make an informed decision as to whether they undertake medical training in Australia, recognising the substantial financial commitment they are required to make and the substantial dislocation involved. The number of IMS in Australia also impacts on available teaching resources. The AMA is concerned that not only are their expectations for employment being unfairly raised, they are also consuming resources that could otherwise be applied to addressing the bottlenecks we have further down the medical training pipeline in registrar training.

We are also unsure as to why the AMC is looking to revise the language used to describe selection pathways for specific student cohorts to more general "entry pathways" rather than targets (Standard 7.1.2). The AMA believes that both are important to ensure doctors from underrepresented and diverse backgrounds are encouraged and supported to train in medicine.

5 Fitness to practise

We are also concerned about an emphasis on fitness to practice and the reference in your correspondence to the MDANZ Inherent requirements for studying medicine. While there may be some value in providing individuals with an opportunity to reflect on the requirements of medical training that might be challenging, the AMA has expressed its concerns about the potentially discriminatory nature of the document in respect of physical ability. We believe that medical students should be considered capable to practise medicine until proven otherwise. Where there are concerns about the physical ability of a medical student or doctor, the same rules that apply to other individuals should apply to medicine, and reasonable adjustments should be made to support the person with the disability (Standard 7).

In this regard the language should be about supporting/enabling students with a range of abilities/disabilities, and should extend to students who have begun studying medicine but who find themselves unable to due to physical injury or otherwise without adjustment.

In closing the AMA has a number of position statements and submissions that are of relevance to the AMC as it reviews the standards including:

AMA Position Statement on Pre-internships in medical school - 2017

MDANZ Inherent Requirements for Studying Medicine in Australia and New Zealand 2016

AMA Position Statement on Safe work environments - 2015

AMA Position Statement on Health and wellbeing of doctors and medical students - 2011

The AMA Council of Doctors in Training next meets in Canberra on 28-29 October 2017 should the AMC like to consult with this group on specific proposals for revisions to the standards.

The AMA looks forward to actively contributing to the review of the Standards for Assessment and Accreditation of Primary Medical Programs.

Yours sincerely

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Federal President

Dr John Zorbas

Chair, AMA Council of Doctors in Training