Re-inventing medical work and training: a view from generation X

Clare A Skinner

ABSTRACT

- Medical career preferences are changing, with doctors working fewer hours and seeking "work–life balance".
- There is an urgent need for creative workplace redesign if Australia is to have a sustainable health care system.
- Postgraduate medical education must adapt to changing medical roles.
- Curricula should be outcomes-based, should allow flexible delivery, and should consider future workforce needs.

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Australia's health system is under pressure. Demand for health services is rising as the population ages and the burden of chronic disease grows. There is a mismatch between community expectations and health service delivery, fuelled by intense media scrutiny and political point-scoring. Medical technologies are becoming more complex, resulting in increasingly specialised and expensive medical care.

Australia's health workforce is also under pressure. Both male and female doctors are working fewer hours,[1] reflecting general community preferences for "work–life balance". Professional roles are changing in the face of increasing litigation, widespread availability of medical information via the Internet, and policy directives that favour growth of the private health sector.

The medical workforce shortage is both absolute and relative: we do not train enough doctors and, once trained, doctors are not working in areas of greatest need. Chronic vacancies exist across the health care system. A survey of New South Wales public hospitals in February 2004 estimated that there were over 900 vacancies at resident and registrar level throughout the NSW system, the majority of unfilled positions being in emergency medicine. The vacancies were not just in rural and outer-metropolitan hospitals, but also in prestigious, inner-city teaching hospitals (NSW Health, unpublished data). Workforce shortages drive an increasing market for casual locum labour, which currently is the only growing sector of the medical workforce.[2]

Given predictions that demand for health services will continue to rise and that the size of the health workforce will continue to fall, we need to think creatively about how to best engage and use the available pool of medical practitioners. Training more doctors is only part of the solution. We also need to reconsider the roles of doctors in the health system, determine the skills and competencies necessary to fulfil these roles, and develop outcomes-based training programs that deliver appropriately trained professionals. We need to better understand the factors that prevent trained medical practitioners from fully participating in the workforce so that we can design and implement work and training practices that recognise and allow for conflicting professional, family and leisure needs.

Changing medical careers

The career expectations of medical graduates today differ vastly from the expectations of their colleagues from previous generations. Research by the Australian Medical Workforce Advisory Committee (AMWAC) demonstrates that junior doctors make career choices based on pragmatic factors, such as income expectations, working hours, length of training time and availability of part-time work, with sense of vocation being a secondary consideration.[3] With the introduction of postgraduate medical programs in the 1990s, graduates are older, more likely to have partners and dependants, and begin their career with higher levels of debt than ever before.[3] Procedural specialties with potential for high private income generation are favoured over generalist specialties in the public sector.

Junior doctors in the current environment also have more choices than ever before. Many have previously established non-medical careers, and the growing market for locum doctors provides a source of generous casual income free from restrictions associated with vocational training programs. The medical workforce is also increasingly mobile, with doctors crossing state, international and disciplinary boundaries to fill lucrative positions, challenging existing systems of accreditation and credentialling.[4]

There are limited data describing future career plans of medical practitioners, but some clear trends are emerging. Casual medical labour is on the rise.[2] Exploration of factors driving junior doctors to leave training positions to work in a locum capacity suggests that recent graduates value job flexibility, autonomy and income. Doctors are increasingly attracted to locum work because it enables them to choose their hours, work location and clinical discipline, and allows them to escape onerous overtime requirements and compulsory secondments expected of registered college trainees.[2] Another emerging phenomenon is the multi-stage medical career, where doctors retrain in related or unrelated disciplines throughout their working life, either to explore personal interests or in response to changing personal, financial or family needs. One thing is certain: it is naïve to assume that the traditional medical career structure, in which a strong sense of vocation drives an individual to selflessly work long hours in substandard conditions, will re-emerge as the dominant model or is a viable solution to current medical workforce problems.

Training the doctors of the future

In medicine, unlike most other industries, professional training is enmeshed with service delivery. State health departments rely heavily on recent medical graduates and vocational trainees to undertake the bulk of day-to-day public hospital work. The majority of post-university learning is unstructured, following an apprenticeship model, with cognitive and procedural skill development assumed proportional to duration of employment. Changing career structures and workforce expectations will require a fundamental re-evaluation of the way we educate and train medical practitioners. Medical training needs to become more flexible and more efficient to meet increasing workforce demand.[5]

To train doctors appropriately, we need to first decide what we want doctors to do and how we want them to do it. Curricula of key competencies have been developed by medical schools, postgraduate medical councils and specialist colleges, but these skills lists are largely based on roles currently filled by doctors and

do not consider the need for an individual doctor to possess competency in the long term or the possibility that a task could be more effectively performed by someone else. The time has come to question the generalist philosophy underlying Australian medical education and to develop outcomes-based educational programs aligned with long-term workforce needs.

Medical education needs to be streamlined. There is a pressing need for governance and coordination of medical education across all levels to prevent duplication and create economies of scale that allow delivery of best-practice teaching. As opportunities for hospital-based clinical teaching become rarer,[6] we need to work out how to make the most of them, using timely theoretical teaching and skill development in simulation centres before patient contact. We need to develop competency-based postgraduate training programs that require registrars to demonstrate acquisition of relevant skills, rather than career progression based on time served and academic examinations. Trainees should be protected as far as possible from low-order administrative and clinical tasks irrelevant to their training needs, through provision of clerical and technical support and delegation of minor procedures to appropriately trained clinical personnel. Career medical officers should be encouraged to fill largely service-oriented medical positions that have traditionally been filled by specialist trainees.

Medical training must also become more flexible. Adoption of a modular approach by the Australian and New Zealand College of Anaesthetists and the Royal Australian College of General Practitioners is an encouraging sign. In the future, it should be possible for an individual doctor to construct his or her own training scheme through a mix of learning modules and experience gained across a number of disciplines. Development by universities and specialist colleges of core and elective training modules, with clearly defined curricula and outcomes, would facilitate part-time and interrupted training, and could be used to build explicit accreditation and credentialling systems. Wider use of modular training systems would allow easier professional "re-invention", making it more likely that a doctor seeking a career change would remain in the medical profession. Modular training may also have a role in continuing professional development and accreditation of overseas-trained practitioners.

A final challenge is to better engage the private sector. Almost all medical training positions are located in the public hospital system, although the vast majority of patient encounters now take place in private, community-based facilities. We need to support the central role of the teaching hospital in professional development of specialist registrars, while allowing trainees better access to patients in private hospitals and outpatient rooms.[7] The rise of fee-for-service Visiting Medical Officer arrangements in public hospitals has had an impact on training, as teaching is not directly reimbursed and may become a secondary consideration during a busy working day. We can no longer rely on volunteers to provide the bulk of medical education, and need to consider how to encourage on-the-job teaching, whether through supportive industrial arrangements for senior clinicians or by direct payment of specialist educators following a business model. The public health system should be willing to observe and learn from workplace innovations successfully implemented in the private sector.

Time to move ahead

The medical workforce is under increasing pressure, and challenges posed by staff shortages will continue to grow. Much has been written about the impending "workforce crisis". It is time to act.

Strong leadership is required and difficult decisions must be made. Federal and state governments need to publicly commit to meaningful, future-driven, long-term reform. Clinicians from all health professions, politicians, health administrators, educators and community representatives need to work together towards finding solutions. In times of increasing health costs and decreasing health resources, we need high-level debate about how to manage and deliver health care, how to allocate health resources and how to effectively train and employ health professionals. We need to move towards clearly defined, evidence-directed goals. The broader community must be educated about current problems and actively engaged in setting health priorities for the future. We must be flexible, creative and courageous.

Competing interests

None identified.

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