

Medical Workforce Training and Employment Workshop: Summary of Outcomes

INTRODUCTION

Approximately 160 people attended a two-day workshop on the Gold Coast in April 1999, which was convened by the Commonwealth Department of Health and Aged Care and the Australian Medical Workforce Advisory Committee (AMWAC). Participants included representatives of medical colleges and professional organisations, registrars, medical students, State and Commonwealth health departments, medical administrators, and consumers. Dr Norman Swan facilitated the workshop.

The aim was to develop practical ways of moving forward on issues of concern regarding the medical workforce which have been identified in two recent reports. These were the *Trainee Selection in Australian Medical Colleges* (also known as the Brennan report) commissioned by the Medical Training Review Panel (MTRP), and *Influences on Participation in The Australian Medical Work force*, commissioned by the AMWAC.

Background issues included concerns about the selection arrangements for hospital based college vocational training programs, particularly given the implications for medical graduates of Commonwealth legislation governing provider numbers. Participants acknowledged that some colleges and employers were already following the general principles espoused in the Brennan report and that others had made progress implementing some of the recommendations contained in the Brennan report.

The workshop aimed to develop principles for change and to devise a meaningful process to achieve this in a short to medium time scale. It was also intended to encourage useful discussion between the interested parties. Participants were told their work would form the basis for recommendations which would be put to AMWAC, MTRP, the Australian Health Ministers' Advisory Council and Health Ministers.

Key issues on the agenda included perceptions that selection and appeals processes for medical training are not transparent and fair. Another was the widespread concern about barriers to greater female participation across the medical work force in the specialties and sub specialties. Some participants also identified the so-called "non-accredited training positions" as an unresolved, and perhaps increasing, source of concern. Although it was stressed by college representatives that such positions are in reality hospital service positions which lack many of the characteristics of a vocational training program placement and which do not come under the auspices of college training programs.

Participants stressed the difficulty of developing uniform proscriptive recommendations, given the necessary complexity and variability of the training systems. All medical colleges are responsible for vocational training, but some are directly responsible for both selection and training, while for others responsibility for selection actually rests with the hospital or employer. In Queensland, for example, there is largely one employer -- the State Health Department -- whereas in Victoria employers are either the networks in metropolitan areas or individuals hospitals in rural areas.

Speakers told the workshop about the political and legal imperatives for addressing these issues including natural justice and the Trade Practices Act, as regulated by the Australian Competition and Consumer Commission and monitored by the National Competition Council. Mr Bob Wells, of the Commonwealth Department of Health and Aged Care, said the Government expected the principles of transparency, fairness and accountability to be applied to training selection and appeals processes and there was a need to continue the reforms which had already commenced.

TRAINEE SELECTION FRAMEWORK

Outcomes

- i. The Brennan report's framework for trainee selection should continue to be implemented, while bearing in mind the need for flexibility, especially as individual college and employer circumstances vary. The agreed framework is:
 - **A clear statement of principles underpinning selection**
 - the aim to select the best possible candidates;
 - the objective of producing the best possible practitioners;
 - the process to be legal; and
 - for the process to be accountable.
 - **Eligibility criteria**
 - there should be a clear statement of eligibility to apply for and be selected for training.
 - **Advertising**
 - there is to be a national awareness of opportunity for all eligible candidates.
 - **Limits to the numbers of training positions**
 - if there is a quota, it should be explicit and openly declared; and
 - limits relating to other factors such as the number of training positions should also be disclosed.
 - **Applications for training positions**
 - applications should be written in a standardised proforma.
 - **References**
 - referees' reports should be written in a standardise proforma with a view to achieving objectivity, comparability and quantification.
 - **The selection committee**
 - the group who make the final decision should have the confidence of the candidate, the profession and the community;
 - the size of the committee should be proportional to the task;
 - they should be prepared to be held accountable for their decision;
 - they should be prepared for their processes and decisions to be reviewed in other forums;
 - the selection process should be:
 - valid
 - reliable
 - feasible
 - evaluation should be built into the process.
 - **Selection criteria**
 - the selection criteria should be documented and published; and
 - the selection criteria must be objective and quantifiable to the greatest possible extent.

- **Conduct of the interview**
 - the interview should be objective and free of bias.

- **Selection**
 - the selection should be based on the published criteria and principles; and
 - the process should be capable of standing external scrutiny.

- **Ranking**
 - selection committees should score and rank candidates using the tools described.

- **Documentation**
 - a record of proceedings should be kept which is sufficient to enable non-participants in the original selection to accurately re-construct processes and decisions; and
 - adequate documentation enables external scrutiny, audit and evaluation of the selection process.

- **Evaluation of the selection process**
 - there should be a formal, regular, inclusive review of the selection process.

The workshop noted that promoting transparent selection, including feedback to unsuccessful applications, is likely to minimise appeals.

1. An essential element in implementing this and the other strategies developed in the workshop was a significantly increased level of collaboration and cooperation among colleges, employers (namely hospitals and health departments) and trainee representatives at national, state and local levels. One aim of this should be a level of consistency across institutions, states and disciplines.
2. State health departments should encourage hospitals and other employers to implement joint selection processes. College nominees on hospital selection committees should be external to the area/region/network within which the hospital is located wherever possible.
3. A single document should be published, including on the Internet, containing all colleges' policies on selection and appeals.
4. Starting dates for the clinical year and job descriptions (such as postgraduate year 1 (PGY1 and PGY2)) should be brought into line nationally to facilitate mobility and maximum access for appropriately qualified applicants. State health departments should work towards implementation of this in 2001.
5. There is a need to continue data collection. Suggestions include a prospective cohort study to investigate factors which influence training and career decisions. (This is currently under consideration by the AMWAC).

Issues canvassed during discussion

The colleges emphasised that much progress has already been made in reforming selection processes, and that steps are being taken to enhance coordination and communication between colleges and other groups, including trainees and employers such as hospitals.

Trainees and administrators, however, told of perceptions that remain with processes not being sufficiently transparent, fair, or accountable. While one surgical trainee said she had found no such problems in her own experience, other trainees gave examples from their personal history as well as that of colleagues.

This supported a finding of the Brennan report that in selection there is sometimes a gap between central college policies and what happens "on the ground" in selection. Apart from developing uniform selection principles, there was a need for both colleges and employers such as hospitals to promote cultural and behavioural changes at all levels of the profession.

It was recognised that the interests of training and service delivery are sometimes in competition. This particularly referred to the so-called "non-accredited training positions" and confusion surrounding their status.

It was also recognised that colleges and employers has to take a leadership role in advising their constituency and trainees that processes are changing and a set of selection guideline will now be universally applied.

A range of other issues were discussed but not endorsed by all participants, including:

- Advertisements should be placed simultaneously and nationally, with uniform closing dates and announcements of appointment.
- Selection processes must be documented and evaluated. Audits should commence within three years and could include the numbers of applicants, appointees, how many complete training, and data on appeals.
- Colleges could consider appointing an ombudsman to audit progress on selection procedures. The ombudsman should be trusted by trainees and have the authority of direct access to the College president. This would also provide a mechanism for Colleges to publicise their progress.
- Trainee advocates should have a greater voice in systems and structures.

SELECTION APPEALS – choosing the most appropriate model

This was one of the unresolved issues in the Brennan report and one of the major reasons for the workshop.

Outcomes

There was majority support for the general approach of the Royal Australasian College of Surgeons (RACS) appeals process which is essentially a staged (that is mediation is tried first), internal mechanism which has limited cost to the appellant, chaired by a respected, external, independent person.

There was only minority support for an external appeals process more in line with the model proposed in the Brennan report. It was felt that an internal process involving external members would allow better consideration of technical issues, and not cost as much

There was consensus that all unsuccessful applicants should be given feedback, and that low cost or no-cost mediation was an important first step in the appeals process.

There was also agreement that anyone chairing mediation proceedings should not chair an appeal on that same decision. The workshop considered that there was a need to minimise bureaucratic structures.

The main features of the model broadly endorsed by the workshop are:

- **Grounds for appeal**
 - that an error in law or in due process occurred in the formulation of the original decision;
 - that relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in making the original decision; or
 - that the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

- **Appeal process**
 - the onus is on the applicant to establish the grounds for appeal;
 - apply in writing attaching such documentary evidence as necessary; and
 - this is forwarded to the censor in chief who may in the first instance decide that an internal mediation process may help to resolve issues.

- **Composition of the appeals committee**
 - the college vice president or another member of the college council appoint by the council;
 - two fellows who are appointed from a panel appointed by the council;
 - two lay members
 - the chairman of the committee is one of the lay members; and
 - the appellant should have the right to nominate a college fellow to the appeals committee and to have an advocate or personal support present during the hearing.

- **Appeals committee**
 - acts according to the rules of natural justice;
 - may inform itself on any matter it sees fit;
 - may invite any person to appear before it; and
 - should act with as little formality as possible.

- **Decisions of the appeals committee**
 - The committee can:
 - confirm the decision which is subject to appeal;
 - revoke the decision;
 - revoke the decision and refer it back to the original decision making body; or

revoke the decision and make recommendations to the college council.

- **Costs of appeal**
 - a nominal fee payable on lodgement of an appeal (it was agreed that in 1999 a fee of \$500 would be reasonable);
 - the appeals committee may recommend that part or all of the fee be waived.

- **Prevention of appeals**
 - publication of guidelines on the selection process, the interview process and dismissal from the training program;
 - the provision of counselling to all unsuccessful applicants;
 - removal of so-called "non-accredited training positions";
 - selection process training for fellows involved in selection'
 - monitoring of performance of training supervisors; and
 - introduction of an internal mediation process to provide the parties with an opportunity to resolve issues before moving to the full appeals process.

Participants also agreed that any appeal process should take place as quickly as possible, that maintenance of confidentiality throughout the appeals process is crucial, and that successful appellants must not be disadvantaged, despite acknowledgment of the possible difficulties of finding a training position.

It was also noted that there are other mechanisms for appeal outside the college system. These vary from state to state but in New South Wales, for example, include the administrative Appeals Tribunal, the Industrial Relations Commission and the Government Relations Employment Appeals Tribunal.

Issues canvassed during discussion

The gap between college policies and the perceptions of trainees and other groups was again identified. The RACS made a detailed presentation of its appeals processes and the steps which had been taken to encourage transparency, fairness and accountability. Nonetheless, several speakers identified concerns with appeals processes, including barriers to their use, including cost where a cost recovery charge rather than a flat fee was levied.

A range of other issues were discussed but not endorsed by all participants, including:

- There should be separate but consistent appeals processes for employers and colleges.
- The Royal Australasian College of Physicians charges a variable fee, with the aim of recovering costs. But there was broad support at the meeting for a flat fee (a separate one for the mediation process and another, probably higher one, for the appeals process). This would help ensure the appeals system is accessible.

The process of review should not attract a fee as it is part of normal college business.

WOMEN IN THE WORK FORCE

Outcomes

There was broad support for colleges and employers to work together to develop more flexible work and training practices, including part time positions, job sharing, and distance based training. Colleges should have clear, unambiguous and transparent criteria and guidelines for part-time training, including the minimum training requirements for part-time training necessary to maintain standards. This should not impose barriers or unreasonable conditions. Employer advertisements should signal a willingness to consider part time or interrupted training.

Colleges, health service hierarchies and opinion leaders in the profession and bureaucracy should take leadership roles in promoting culture change among consultants, managers, fellows and candidates.

It was recognised that many of these measures were not gender specific and would be of benefit to men as well as women.

Issues canvassed during discussion

Once again, some discrepancy was identified between college and employer policies, which often acknowledge the possibility of flexibility in training programs, and what happens in reality.

Several doctors and administrators spoke of the barriers confronting women, as well as the changing expectations of the younger generation of doctors (See Appendix D for speech transcripts). Apart from process issues, a need was identified both colleges and employers such as hospitals, to encourage cultural change at senior levels of the profession, to make a fairer, more flexible workplace.

Dr John Horvath, of the AMWAC, said trends in female participation in the medical workforce - towards part-time, flexible work practices - posed dilemmas for the future. It was not clear whether increasing female participation would result in doctor shortages, given the trend for women to work fewer hours than men. Nor was it clear if making work and training environments more attractive to women would lead to them working longer hours or participating more in disciplines that currently have comparatively low numbers of female practitioners.

The data presented by the AMWAC showed that while women comprised approximately 28 per cent of the medical workforce, in 1998 they represented 43 per cent of vocational trainees and 53 per cent of commencing medical students. Favoured areas of practice and training were general practice, psychiatry, pathology, public health medicine, paediatric medicine and anaesthesia.

AMWAC believes health departments, hospitals and other employers should seek to make the best use of their highly trained work force, through flexible work practices, good clinical practice, promoting re-entry and ensuring appointments are fair and non discriminatory.

Again, a range of other issues were discussed but not necessarily endorsed by all participants. These tended to be either general issues associated with the training and employment environment or issues that were more specifically gender based.

The general issues included:

- Continuity of training should be offered, so that once trainees are in a program, they can have time out without having to reapply. Update packages should be developed to facilitate re-entry to training.
- Colleges and employers should consider establishing job share registers as a matching system service.
- Training should be less time-based.
- Meetings should be held in working hours at all levels of seniority. Similarly, formal training should occur during normal working hours recognising that this could pose implementation difficulties.
- Rostering should be as regular and predictable as possible with as much notice given as possible.
- Employers should assist with access to extended-hours child care services.

- Trainees' parental leave rights should be clarified.
- Contracts should be longer than one year but there was debate about what would be a practicable length, with some concerns expressed about the implications of longer contracts for rural health services.
- A teamwork approach to patient care should be fostered, rather than the "heroic individualism" of one doctor being solely responsible.
- There should be investigation of cultural issues which might discourage specific groups.

The more gender specific issues included:

- Systems should be introduced to encourage women's access to mentors/advocates, such as senior, high profile women in the organisation.
- There should be an attempt to redress the gender imbalance on college and employer bodies, including appointing women as directors of hospital training, and ensuring there are formal selection procedures for committee membership.

There was disagreement over whether there should be formal affirmative action programs.