“Educating our future doctors: contemporary issues in medical school education in Australia”

Educating our future doctors has never before been such a high stakes activity. The explosion of medical knowledge, new models of health care delivery, workforce imperatives and demands for greater social accountability are driving change in educational practice at an international level. Over the past decade, Australian medical schools have been at the forefront of many of these changes, as educators seek to consolidate this country’s reputation as a provider of high quality medical education.

A major priority has been to ensure that the content of medical school programs is relevant and evidence-based. With competing demands on curriculum time, there has been a pressing need to define the core knowledge, skills and attitudes required by medical students to be practice-ready for their junior doctor years. This has been, and will continue to be, a complex and challenging exercise. There has, for example, been robust, and at times acrimonious, debate about the depth of bioscience knowledge required in entry-to-practice medical programs, in part fuelled by publication of the Australian Medical Education Study.¹

Medical schools have also faced the task of extending the core curriculum to reflect changing emphases in health care delivery. Specific expertise, such as teamwork, interprofessional practice, modern management of ageing and chronic illness self-management support, is required to sustain new models of practice. The importance of laying the foundations of this expertise in medical school is increasingly being
recognised, particularly within the broader context of the quality and safety movement.²

Considerable energy has also been devoted to optimising the efficiency and efficacy of medical school education.³ New theoretical models of learning, as well as outcomes of educational research, are being used to define best practice.⁴ There has been an increasing emphasis on developing pedagogical approaches that help students effectively appraise information and apply problem-solving frameworks. Substantial progress has also occurred in the area of clinical skills acquisition, with application of techniques such as simulation-based learning, hypothesis-driven physical examination and deliberate practice.⁵

The delivery of quality medical school education in this country has been challenged, however, by economic, logistic and workforce imperatives. One of the main drivers has been the need to address the shortage of medical practitioners, particularly in rural areas. This, combined with the expansion of the international student market, has led to a dramatic surge in the medical student numbers in Australia, from 1287 in 2004 to a projected 3018 by 2014.⁶ The increasing demand for places has been accompanied by a growth in the number of medical schools between 2000 and 2008 from 10 to 19, with at least four other universities currently pursuing the right to establish medical programs.
Significant challenges in co-ordinating clinical placements have arisen as a result of increasing student numbers and changing educational practices. The teaching hospital is no longer the sole provider of clinical education, and a wide variety of other locations, including community settings and simulated learning laboratories, are now employed. Considerable effort has been required to foster consistancy of curriculum delivery across these dispersed learning environments. Various bodies, such as the Australian Medical Council (AMC) and Health Workforce Australia, are working to ensure medical students receive high quality supervision as well as suitable clinical exposure.\(^7\)

Maintaining a well-trained medical education workforce, nevertheless, remains at the heart of educating our future doctors. A variety of programs, such as Teaching on the Run,\(^8\) are now offered to help clinical teachers enhance their expertise in this area. Furthermore, a range of post-graduate qualifications is available for those wishing to explore the discipline in more depth or assume leadership roles in medical education.

A greater emphasis on academic development has contributed to strengthening of relationships with other areas of medical education. The continuum of learning is more clearly articulated than in the past; specifically, the Australian Curriculum Framework for Junior Doctors now provides a pivot between medical school education and vocational training.\(^9\) Medical schools are also strengthening their relationships with the wider community, in recognition of their social obligations. This has been exemplified by the development of the Indigenous Health Curriculum Framework\(^10\) as
well as selection procedures that aim to address equity of access for disadvantaged applicants and shape the medical workforce so it better serves diverse patient populations.

With these developments has come a greater recognition of the need to evaluate the efficacy and cost-effectiveness of innovation in medical school education. It must be acknowledged that much of the reform in medical education has preceded rigorous inquiry, and the discipline has been rightly criticised for this.\textsuperscript{11} Accordingly, there has been a greater commitment to undertaking programmatic research and implementing strategies that feed outcomes back into educational policy and practice.

In recognition of the importance of educating our future doctors, the MJA today begins a series of articles exploring the changes that are taking place in medical school education in Australia.

(799 words)

Acknowledgements

The authors would like to acknowledge Associate Professor Jennifer Weller and Professor Ian Wilson for their helpful comments.

Conflict of interest
Jennifer Conn has received consultancy fees from the AMC for sitting on medical school accreditation panels and advisory groups. David Ellwood is a Director of the AMC and Chair of the Medical Schools Accreditation Committee.

References


