



Changing for Good: What We Learned in 2020

The impact of COVID-19
on medical schools
in Australia and New Zealand

July 2021

EXECUTIVE SUMMARY

This report explores how medical schools responded to the impacts of COVID-19 in 2020, and how we might build on some of the changes that occurred to achieve fundamental improvements in medical education and training in Australia and New Zealand.

Medical schools graduated close to the anticipated number of new doctors at the end of 2020 – a significant feat given the size and number of shockwaves sent through the system by the pandemic. We saw COVID-19 drive a complete rethink of some elements of training previously considered sacrosanct, a rapid acceleration in the adoption of technologies, and the forging of stronger, more widespread partnerships and collaboration.

In many cases, these sudden and massive changes created strong potential for lasting improvement. Since the end of the first COVID-19 lockdown, medical schools have been asking themselves, ‘Which of the new ways of working do we want to keep and build on into the future, and which do we never want to see again?’.

This report provides some answers to these questions. It is informed by responses to a survey run by Medical Deans Australia and New Zealand (Medical Deans)¹ midway through 2020 about member schools’ experiences during the initial lockdowns, and subsequent discussions among our members’ communities of practice. It also draws on the contributions of presenters and participants of the Medical Deans’ 2020 Annual Conference, which was themed around the impacts of COVID-19.

The innovations and challenges that arose during the year are grouped into three areas:



1. The role of online learning



2. Shared responsibility for clinical learning



3. From collaboration to partnerships

Medical schools are looking to capitalise on the resourcefulness and innovation of 2020 in all the ways highlighted in this report. Whilst the impact of the pandemic on medical education and training was immense and costly – both financially and personally for everyone involved – such a scale of disruption provides us with a unique opportunity for step-change. To fully realise this potential, we will need to work in partnership with all those involved: students, health services, prevocational training, specialist colleges, regulators, and governments.

Medical Deans is committed to fostering these partnerships and keeping the focus on the lessons learned during the first year of the pandemic, so that the early benefits already seen are retained and their future potential is realised.

¹ <https://medicaldeans.org.au/>

Overview



1. The role and value of online learning

As campuses closed early in 2020, schools employed a combination of pre-recorded sessions and interactive online lessons to deliver much of the non-clinical, and a small part of the clinical, medical curriculum to students. This created a sense of unity amongst students in different geographical locations as they all accessed the same lessons online – reducing disparities sometimes faced by those in regional and rural areas.

The move out of the lecture theatre allowed more flexibility for students in accessing lessons and interactivity, through online chat functions, and encouraged the use of advanced digital learning platforms. Small group tutorials used online tools to imitate some aspects of face-to-face clinical teaching and assessment, for example, Zoom rooms for interactions with actors or OSCEs².

But there were significant problems associated with moving online. Students (and staff) suffered from online fatigue and the loss of connection with their peers, tutors and supports during 2020. Also, students' access to adequate technology and learning space offsite was not always adequate, despite schools' best efforts. Finally, medicine uses a very hands-on, apprentice-based educational approach, and there was only so much that could be done remotely.

The future of medical education lies in a blend of face-to-face and remote learning and assessment. Getting the balance right will be an ongoing priority for medical schools.

What we want to take forward

- Equity of learning opportunities across rural, regional, and urban locations using digital technology
- Enhanced learning outcomes through a blend of remote and face-to-face teaching and assessment

The ongoing challenges

- Equity of access for students to technology and space for remote learning
- Balancing the benefits of online learning with the need for human connection and immersive, onsite learning



2. Shared responsibility for clinical learning

The need to maintain clinical placements saw medical schools and health services working much more closely together to ensure the success and safety of placements. This 'shared responsibility' approach was widely welcomed by Australian medical schools (New Zealand already has a system of joint custody for pre-interns) and will be the subject of further exploration moving forward. Likewise, the move to longer placements, often in more general wards or health care settings, was

² *Objective Structured Clinical Exams (OSCEs)*

positively received, with students reporting feeling more connected to the other health professionals they worked with and more able to make a valuable work contribution to patient care.

The work undertaken to more clearly define the role of final-year medical students within the healthcare team – for example, the Assistant in Medicine role developed in NSW – was also welcomed by supervisors and junior doctors, who said it helped them to better understand the contribution students could make to the clinical teams, including which tasks they could delegate to students and which they could not.

On the negative side, the ongoing lack of clinical training opportunities in community-based settings – aged care, in particular, and some areas of general practice – only worsened during the pandemic. This issue is greatly concerning, given the aging populations of Australia and New Zealand³ and the increased need for non-hospital care to manage the chronic and comorbidity conditions that typically occur in older populations. It will take sustained collaboration between medical schools and health services moving forward to ensure that there are sufficient quality clinical training opportunities for medical students in community-based health care settings.

What we want to take forward

- Shared responsibility for medical students' clinical placements as an essential part of the health system
- More emphasis on student competencies and less on clinical rotations in specific disciplines
- Creating a culture of support for students transitioning to practice

The ongoing challenges

- Shortage of clinical training opportunities in community-based care



3. From collaboration to partnerships

The agility and breadth of the response by medical schools to the impacts of COVID-19 depended on a strong capacity for teamwork within and between medical schools, a closer connection with students, and strong partnerships with health services. Feedback from medical school staff indicated that the collaborative work of 2020 – including the maintenance of clinical placements, the development of shared common core competencies for graduating students, and an interactive focus on student health – were amongst the most highly valued innovations of the period.

COVID-19 also emphasised the need for greater collaboration with other health professional programs. The rapid uptake of telehealth during the pandemic steered health services further toward service delivery through multidisciplinary teams, supporting healthcare providers to work to the top of their scope of practice. The importance of teamwork and the collaborative role of the doctor in these teams has now become fundamental to the future of medical training and practice.

³ *The number of people aged over 65 in Australia will more than double from 4 million to 9 million between 2017 and 2057 [Department of Health, National Medical Workforce Strategy Scoping Framework, July 2019 (page 21)]. In NZ, the number of people aged over 65 is likely to almost double by 2043 [Stats NZ (19 October 2016) National Population Projections].*



Another workforce issue which came under the spotlight, due to the closing of national borders, was the fragility of national health workforce models in Australia and New Zealand, which currently rely heavily on International Medical Graduates (IMGs) to support workforce shortages. The pandemic highlighted the urgent need for a more self-sufficient workforce, which can only be delivered by a more connected medical education and training pipeline that enables our future doctors to choose and progress a career in the locations and specialties most needed by our communities.

What we want to take forward

- Stronger collaboration between medical schools and across the training pipeline: on issues including assessment, transition to practice, good practice use of technology, advocacy on education and health workforce policy
- Increased partnerships with students, including co-design of student support initiatives and advocacy on support for student health

The ongoing challenges

- Training doctors of the future to work in multi-disciplinary teams
- Over-reliance on IMGs to fill medical workforce shortages



1. THE ROLE AND VALUE OF ONLINE LEARNING

1.1 Strong sense of unity between students

As campuses closed and medical students shifted to remote learning early in 2020, students based at the different campuses and regions were increasingly able to access the same learning opportunities and tutors. This engendered a sense of unity across year cohorts and increased equity of access to learning opportunities, regardless of geography.

Remote training was rolled out through a combination of pre-recorded video, live online teaching, virtual small group teaching, and tele-supervision of students. The sample feedback below illustrates the changes implemented within medical schools:

- **Auckland:** *We have done much more synchronous learning across sites – we have eight sites in each clinical year across the north island - and we're going to keep that.*
- **Newcastle:** *We've found that the expert facilitating a learning session can now be based anywhere and it works well.*
- **UNSW:** *We have students at five metro hospitals and at least five rural ones, plus those in GP placements, who can now join each other in learning activities online. Prior to this, the rural students often felt left out of tutorials and activities that the metro students could get to.*

These changes represent the start of a technology-enabled step change in the way medical students are trained in Australia and New Zealand. The opportunity now exists for students in urban areas to gain greater exposure to rural health and rural experts online, and for rural and regionally-based students to do a substantial amount of their training outside urban centres with the aid of tele-supervision. This aligns with the approach of the (draft) National Medical Workforce Strategy (NMWS) 2020, which looks to technology to support equity of access to healthcare and medical training across geographical locations. By expanding the use of remote learning in medical school, we are effectively laying the groundwork for a more seamless training continuum for students and doctors, regardless of whether they train or practice in urban, regional or rural locations.

1.2 Blending online and face-to-face learning

The combination of pre-recorded learning sessions and interactive online lessons that was adopted during the COVID lockdown has now been widely embraced within medical schools for pre- or non-clinical learning. University of NSW's Associate Dean, Education and Innovation, Adrienne Torda, points to a wider, pre-pandemic context for this transition⁴: "Globally, questions have been raised regarding utility and format of the pre-clinical content taught in medical programs in the junior years, particularly lectures, which have increasingly low attendance rates. There is emerging evidence that blended approaches to education meet the connectivity, flexibility and interactivity expectations of learners, and have potential to combine the best of both online and face to face teaching."

⁴ Adrienne Torda RACP - Internal Medicine Journal Personal Viewpoint Date Submitted by the Author, 24-Apr-2020



The sample feedback below from 2020 supports this emerging evidence:

- **Sydney:** *The live Zoom component of the flipped classroom, with two experts (one monitoring chat), has proven very interactive and popular compared to a large lecture theatre. It also allows for more polling, which the students enjoy. With a cohort of 270, we saw increases from an average of 60-80 participants [25%] in lecture theatre mode to up to 210 participants on Zoom [75%].*
- **UNSW:** *The addition of online learning resources has led to improved interaction for students who don't like to speak in big sessions – typing in chat is more comfortable for them. Also, students have reported a preference for online practical classes, now run largely as demonstrations. They are better able to follow and understand these classes online.*

For medical educators, the switch to real-time, remote classes meant teaching via digital platforms such as Blackboard, Collaborate, Ultra, Zoom and Teams. This allowed more effective flipping of classroom⁵ and access to advanced learning platforms using artificial intelligence systems (e.g. Sophya AI)⁶. Small group tutorials used online tools to imitate some aspects of face-to-face clinical teaching and assessment, for example, Zoom rooms to run interactions with actors or OSCEs⁷.

The University of Notre Dame Australia's Dean of Medicine, Gervase Chaney, told the 2020 MDANZ Annual Conference that there was an opportunity to implement long-lasting change: "I think we've learned that if we are going to get value, we're not going to be bringing our students on to campus four or five days every week. We'll be looking at a more flexible learning approach and they can still be doing some clinical skills training – like the history-taking over Zoom or other online platforms. It's a case of how we normalise this so that when students step into the clinical space, it's a natural step for them."

Moving forward, training and access to a suite of quality software applications that are broadly used across Australia and New Zealand to deliver quality medical education and assessment will be important. Examples of good and best practice will be useful for medical educators to access and to learn from.

When it comes to clinical training, however, the study of medicine requires a significant component of onsite, observational and hands-on learning and questioning by students, and role modelling by clinicians of how they treat their patients. "There is so much subtlety in the way you learn in a clinical environment that it cannot be properly replicated online," says Professor John Fraser, University of Auckland's Executive Dean of Medicine and Health Sciences.

Consequently, the disruption to clinical placements in 2020 due to COVID-19 was enormously challenging for medical schools and students.

In the case of the many international clinical placements scheduled for students, one of the early responses was to organise domestic alternatives, with medical schools frequently collaborating to find solutions for one another. Clinical placements in Australia and New Zealand were also

⁵ *Flipped classroom is a pedagogical approach in which direct instruction moves from the group learning space to the individual learning space, and the resulting group space is transformed into a dynamic, interactive learning environment where the educator guides students as they apply concepts and engage creatively in the subject matter (The Flipped Learning Network, 2014).*

⁶ *Adrienne Torda RACP - Internal Medicine Journal Personal Viewpoint Date Submitted by the Author, 24-Apr-2020*

⁷ *Objective Structured Clinical Exams (OSCEs)*



significantly disrupted during 2020, and the ongoing issues related to these placements are discussed in Section 2.

The University of Sydney Medical School's new MD Program

"The pandemic has accelerated our vision for MD2020"

Professor Jane Bleasel, Director of Sydney Medical Program & Director of Academic Education.

On January 28 we launched a major revision of our MD program, having no idea of the challenges the school would face in the context of COVID. We wanted to move away from didactic, traditional teaching to a more student-centred and blended program.

We had decided on a flipped classroom methodology, with multiple short videos for knowledge content, and application of this knowledge with active learning on campus and in clinical schools. Towards the end of 2019 we had hundreds of videos to do and I had begun questioning my sanity. I had no idea how serendipitous our efforts would prove when COVID-19 struck.

Online learning can be interactive and engaging for students – we use PollEverywhere and the chat function and have found that both our campus and group sessions are much more interactive.

Digital team-based learning (eTBLs) has been a great success, with standardisation of the tutors for all students, compared to the previous inconsistency in quality. We use only two tutors for 300 students, as opposed to 10 tutors for face-to-face groups, which enables us to select the best tutors. The student rating for eTBLs has been the highest on record [i.e. over five years].

Another innovation has been video resources using a patient with a disease of the week (e.g. rheumatoid arthritis). Students watch these prior to clinical sessions and find them incredibly helpful.

COVID has also accelerated the introduction of Workplace Based Assessments for Year 4 students.

In essence, the pandemic has allowed us to be creative and accelerated our vision for MD 2020.

1.3 Online Challenges

Equity of access for students

Widespread uptake of remote learning in future will depend on all medical students having access to adequate technology and offsite learning space.

Professor Fraser: "The presumption in delivering medical training online is that all students have equal access to the technology, and that presumption is not correct. Technology comes at a cost and not all students have enough resources to meet their technological needs. Also, the idea that each student has a space of their own to do their online learning is not always the case. Lots of students share accommodation, so what do you do when you have six students in one living area all trying to study online? We've also been very aware that some students are living in large families with very limited living space."

We need to implement solutions for these issues to ensure that remote learning does not inadvertently create inequities which disadvantage some medical students and inhibit the realisation of the full benefits technology can provide.

The need for human connection

The loss by students of a human connection with their peers and teachers was extremely stressful for many, particularly for international students, some of whom were far away from home for the first time. Another cohort at a particular disadvantage were the first-year students who did not get the chance to attend their university campus or make friends in this new phase of their life before the COVID lockdown.

There are very real benefits to be derived from remote learning but one of the challenges in embedding these innovations will be balancing the benefits with the social, personal and developmental needs of students.

UNSW's Adrienne Torda summarised this issue in an article midway through 2020:⁸ "Some important aspects of university life such as such as friendships, personal identity development, exposure to diversity and self-care skills are much harder to achieve in a solely online environment,". "As we develop plans to re-introduce face-to-face teaching, we need to ensure that these are integrated with, and informed by, the advances made in medical education during [2020]."

What we want to take forward

- Equity of learning opportunities across rural, regional and urban locations using digital technology
- Enhanced learning outcomes through a blend of remote and face-to-face teaching and assessment

The ongoing challenges

- Equity of access for students to technology and space for remote learning
- Balancing the benefits of online learning with the need for human connection and immersive, onsite learning

⁸ *ibid*



2. SHARED RESPONSIBILITY FOR CLINICAL LEARNING

2.1 Medical students as part of the health workforce

In the midst of a crisis for health services that was unprecedented in living memory, the initial response of many health service providers was to cancel medical students' clinical placements. Health services cited their inability to supervise student learning due to their own increased workload in preparing for COVID patients, the lack of available PPE⁹, concerns about exposing patients to an increased number of health workers, and safety concerns about students and staff.

The loss of clinical placements was a disastrous prospect for medical schools and students in their final years of study and threatened a shortage of junior doctors in the medical workforce in future.

Medical schools worked closely with their health service partners to address the concerns and support their students' placements being reinstated. Medical Deans worked with key stakeholders, including the Australian Medical Council (AMC), the Medical Board of Australia (MBA), the Australian Medical Students' Association (AMSA) and health jurisdictions, to develop and release a set of principles identifying how medical students could safely contribute as a part of the health workforce response to COVID-19. The workforce shortages occurring within health services due to junior doctors having to quarantine also emphasised the role medical students could play as part of a 'surge' workforce response, by performing important basic tasks that freed up doctors to deal with more complex work.

The outcome was that medical schools and health services came together to co-design approaches which enabled clinical placements to go ahead in ways that were safe and productive for students, health services and patients.

Initially, the pandemic emphasised the natural tensions which exist between students' learning needs and their role in providing patient care during clinical placements. Now, as a result of the work done to reinstate and maintain clinical placements during COVID-19 outbreaks and lockdowns, medical schools are hopeful that the longer-term outcome will be increased recognition within the health sector of the need to maintain clinical placements in future crises – both to support the continuity of the medical workforce pipeline, and for the valuable role later-year medical students can play as the newest participants in the medical workforce.

2.2 Shared responsibility between medical schools and health services

One of the defining features of the new-style clinical placements of 2020 was the emphasis on shared responsibility between medical schools and health services.

Medical schools collaborated with each other and with health services on a range of models (e.g. University of Newcastle's junior medical officer buddy system) and paid positions for medical students as part of the surge workforce (e.g. Queensland's Physician Assistant role and the Assistant in Medicine role in NSW). While remunerated roles already existed for final year students and pre-interns in other countries, including New Zealand, they were a first for Australia.

⁹ *Personal Protective Equipment*



These new approaches to clinical placements had the following features in common:

- the learning needs of the student were explicit and central
- the role of the student, and their scope of practice within the healthcare team, was more clearly defined and articulated
- medical schools and health services shared core responsibilities for students and the success of their placements.

There was strong and widespread support from Australian medical schools for the benefits brought by this shared responsibility – sometimes called “joint custody” – for medical students on placement or working within healthcare environments.

Assistant in Medicine role

Dean of Western Sydney University’s School of Medicine, Professor Annemarie Hennessy, worked closely with the other NSW medical schools and the NSW Health Department to develop the Assistant in Medicine (AiM) role. Their goal was for students to be ready to provide additional medical workforce when needed. (e.g. in cases where junior doctors were quarantined due to COVID-19 contact), while at the same time enabling the continuation of clinical training placements.

The AiM role in NSW hospitals was offered to final-year medical students from the seven NSW medical schools. The AiMs worked up to 32 hours per week, with eight additional hours per week quarantined for students’ education.

Shared responsibility for students was a critical aspect of the AiM role: as employees, the AiMs needed to be supervised by the JMO units; for medical schools, the key issue was aligning their training with the medical program curricula.

Professor Hennessy: “So much about the success of what we achieved in 2020 fed off a five-year process. The Ministry had been in open discussion with us about having a greater line of sight of what students do in final year so they are better prepared; they were ready, we were ready, the support of the other Deans was in place, so it wasn’t actually just a COVID response. I think there are so many positives about it; the challenges will be adjusting the curricula and getting accreditation to follow.”



Trainee Internship in New Zealand

New Zealand's formal pre-intern role acts as a buffer year between graduation and full internship, supporting students' transition to practice. The system works well in NZ and many educators would like to see a similar model of shared responsibility implemented in Australia.

The Chief Medical Officer of Nelson Marlborough Region, Dr Nick Baker, told the 2020 MDANZ Annual Conference that the pre-interns' role in the medical workforce made a difference to their approach during the pandemic: "Our first reaction was to exclude them due to concerns about their safety but many of the pre-interns objected because they're part of the workforce in New Zealand, and we quickly brought them back."

Dr Barker believes that a transition year is the best option for all medical students, given the complexities of the intern role: "First there is the pressure around long hours and the emotional challenge of dying patients and dealing with families; secondly there is the ongoing challenge of medicine – it's always unpredictable and you're constantly learning; and thirdly there's the administrative challenge of doing your job. It is too much to expect someone to walk into the job and pick up all those three new roles instantly."

Pre-interns in New Zealand do not have the responsibility of dealing with patient families or the pressure of being on call. Their training is enabled by a central, national e-portfolio site, which allows access for both an educational supervisor and a clinical supervisor; the education supervisor endeavours to stay with the pre-intern for that and the following year, providing mentoring with emotional crises as well as checking the learning progress of the student.

The AMC's Prevocational Council is currently developing recommendations around an e-portfolio for Australian interns, and eventually for specialist training. Australian medical schools are advocating for the e-portfolio to be extended into medical programs to support a more connected training continuum.

2.3 Longer clinical placements & more generalist training

The need to minimise patient exposure to multiple clinicians during the pandemic led to the cancellation of clinical rotations in some medical specialties (e.g. obstetrics and gynaecology, intensive care). Instead, students from many schools were placed for longer periods¹⁰ in general wards caring for patients with a range of medical conditions.

The Deputy Vice Chancellor, Tropical Health and Medicine at James Cook University, Richard Murray, believes this provided greater exposure for students to whole-of-patient care: "The clinical phase of medical education has traditionally been carved into different rotational experiences across medical disciplines and cemented in place through departments, budgets and staffing. COVID-19 has driven more learning around the integrated experience of patients. Rather than curriculum by a set of

¹⁰ Not all programs adopted longer placements. University of Western Australia, for example, moved to shorter placements, which provided the school with insight into the minimum time required to develop specific clinical skills. This has promoted UWA to reconsider the length of placements in some disciplines where placements are at capacity.



rotations, you have curriculum according to people of all ages and with all sorts of problems, which are often complex and interrelated. Learning is more integrated now.”

Students were more frequently embedded in health workforce teams for longer periods of time during these clinical placements. They reported feeling more connected to the other health professionals they worked alongside, feeling more supported and valued by their team, and more able to make a valuable work contribution to patient care.

Also supporting this more generalist approach was the co-development by schools of an agreed set of core competencies needed for final-year medical students to progress to graduation. This unprecedented collaboration between universities saw medical schools working together to co-develop the common core competencies as a means of quality assuring the rapid and extensive changes made to their programs and placements due to the pandemic. The core competencies, were developed through the Medical Deans’ Medical Education Collaborative Committee (MECC), based on the schools’ own course outcomes and aligned with those required by the Australian Medical Council (AMC).

Sample feedback below illustrates the positive response from many educators to the greater emphasis on competencies in both Australia and New Zealand:

- **Deakin:** “We now have clear competencies mapped for internship - extended to the penultimate year. It is now less about the rotation and more about the competencies”
- **Auckland:** “Based on our local graduate learning outcomes, we are emphasising core competencies over disciplinary learning outcomes. We are emphasising generic skills and capabilities”

2.4 Challenges

Lack of opportunities in community-based care

A pre-existing lack of clinical training opportunities for medical students in community settings – in aged care in particular, and in some places, in general practice – only worsened during the COVID-19 pandemic.

GP placements became variable, with practices scrambling to secure the PPE needed to provide patient services and tending to view medical students as an additional burden rather than as part of the health workforce response.

National and international studies show that health systems which provide strong primary care are more cost-effective and associated with a more equitable distribution of healthcare across the population¹¹. Yet GPs are not resourced in the same way as hospitals to provide clinical training for medical students, which fuels the over-emphasis on clinical training in hospitals rather than GP clinics. Further constraints during 2020 highlighted the need to grow the number of GP training opportunities in future, so that Australia and New Zealand are better able to meet the health needs of their populations.

In the case of aged care, problems associated with the residential aged care model meant that even prior to the pandemic, there were few opportunities for medical students to learn from doctors and supervising clinicians in community-based aged care. These limited training opportunities shut down completely in 2020, as facilities moved to shield their vulnerable elderly residents from COVID-19.

¹¹ *National Medical Workforce Strategy Scoping Framework, 2019, p.7*



We know that the aging populations of Australia and New Zealand¹² will increasingly require non-hospital-based care to manage the chronic and comorbidity conditions that typically occur in older populations¹³. If these needs are to be met, medical schools and health services must work together and with governments to ensure more quality clinical training opportunities are available for students in both community-based aged care and general practice. Supporting appropriate supervision in this context is a key challenge which needs to be addressed.

Creating a culture of support for transition to practice

There is growing awareness that universities and health services need to have robust systems in place to ensure a more supportive transition for medical students at that critical point of transition from medical school to practice.

The University of Queensland's Deputy Executive Dean and Medical Dean, Professor Stuart Carney, sees the increased collaboration between health services and medical schools in 2020 as a positive step toward creating a culture of support for graduates and interns in their transition to practice. "I think there's an opportunity for us to review our systems and processes, in partnership with students and employers, to create a culture in which graduates feel safe to share information that could better support them as they make that transition into work," Professor Carney says.

A significant barrier to sharing information is that students and graduates may fear they will be stigmatised if they ask for support to meet their individual physical or mental health needs or caring responsibilities when transitioning to practice. On the health services side, employers may have concerns about their capacity to provide additional support and the subsequent implications from an employment law perspective.

Medical Deans joined with representatives of health jurisdictions, junior doctors and prevocational medical councils during 2020 to identify ways to de-stigmatise the culture, so that students and graduates seeking support to transition feel safe to do so, while those providing support recognise the institutional, individual and community benefits of a healthy workplace environment. Medical Deans' work to engage stakeholders on this issue is continuing in 2021.

What we want to take forward

- Shared responsibility for medical students' clinical placements as an essential part of the health system
- More emphasis on student competencies and less on clinical rotations in specific disciplines
- Creating a culture of support for students transitioning to practice

The ongoing challenges?

- Shortage of clinical training opportunities in community-based care

¹² The number of people aged over 65 in Australia will more than double from 4 million to 9 million between 2017 and 2057 [Department of Health, National Medical Workforce Strategy Scoping Framework, July 2019 (page 21)]. In NZ, the number of people aged over 65 is likely to almost double by 2043 [Stats NZ (19 October 2016) National Population Projections].

¹³ 60 per cent of the population over 65 years of age in Australia report having two or more chronic conditions.



3. FROM COLLABORATION TO PARTNERSHIPS

3.1 Increased collaboration by medical schools

The agile response of medical schools to the impacts of COVID-19, particularly shifting the delivery of much of the medical program online, depended on a strong capacity for teamwork within and between schools.

“The challenges of COVID made us create these dynamic and interactive education teams consisting of students, academics, professional support, design and IT staff all working together on re-developing format, content and assessments,” says UNSW’s Associate Professor Torda. “At university level we did this across faculties; nationally, we worked more closely together, through Medical Deans in particular, to share and solve problems.”

Feedback from medical school staff in 2020 indicated that the collaborative links forged during this time were amongst the most highly ranked innovations of the period. Examples include:

- Collaboration between academic and educational support staff to run online teaching activities and re-design activities to work well online
- Collaboration between members of Medical Deans MECC on the core competencies required for final-year students to graduate
- Collaboration on advocacy and information exchange through other Medical Deans member networks (e.g. Medical Deans’ principles to underpin students being supported to continue clinical placements)
- Creation of a new online community of practice, the Student Support Network, for member school staff working in student support roles.

Assessments

There were more questions than answers about how to ensure consistent and effective assessment as remote assessment became a necessity during to the pandemic.

Medical schools and the AMC struggled with how to ensure the safety and competency of graduates in the disrupted environment of 2020, while students worried about how they would perform in assessment given the massive changes in delivery of their education and perceived gaps in clinical training.

Curtin Medical School’s Director, Learning and Teaching, Professor Sandra Kemp, told the 2020 MDANZ Conference that the time had come for a review of assessment at the systemic level. “The last six months have shown us that we can assess a lot of skills in a digital environment but have also brought attention to some of the skills and some of the behaviours that we cannot. We need consensus as assessment experts on these areas. Our pivot point here is that we’ve done a lot of sharing of our resources and working together, and moving forward there’s an opportunity to pool resources to develop assessment collaborations, to share the burden that sits around robust assessment.”

One of the issues will be graduate readiness: “Some of our graduates are ready at different points; if their education has been disrupted in some way, it may be at a later point. It’s a case of understanding that different people take different lengths of time, have different attention to learning and different experiences, but our mechanisms aren’t really well placed for that kind of decision making. Also, should we think about moving away from time-based progression, moving to flexible assessment of progression following the competency of our students?”

Chair of the AMC Medical Schools Accreditation Committee, Professor Geoff McColl, also supports systemic change: “What are the key components of the learning experience for our students in this complex ecosystem that is now the medical school? I think it’s a good time not just for an evolution but a bit of a revolution in thinking about the taxonomy of that.”

3.2 Working together to support student wellbeing

Medical students were under a great deal of pressure in 2020 due to uncertainties about the delivery of their program, whether clinical placements would be available to them, how they would be assessed given the need for social distancing, and the loss of connection with their peers and teachers. International students faced a particularly difficult set of circumstances¹⁴.

The challenges for schools were extending health and counselling services to students during the lockdown, as well as responding to students’ understandable desire for certainty at a time when public health information and policy was in a state of flux.

Communication between staff and students deepened as medical schools worked through the implications of the new COVID rules and reached out to students and their representatives to connect and provide information, reassurance and support.

While recognising the pressure placed on students by the pandemic, 3rd Year medical student and President of the Sydney University Medical Society, Catherine Zheng, told the 2020 MDANZ Annual Conference that there was also a greater sense of community between students and staff: “We’ve had countless Q&A sessions, via Zoom, with the heads of our years, with the Dean with the Head of School. Instead of information filtering from the faculty, with the medical society as a medium to the students, we’ve been able to have these conversations together and I think we’ve built a sense of connectedness and community that we haven’t had before, in the face of the pandemic.”

The provision of new funding from the Australian Government to support mental health first aid (MHFA) training for medical students came as a very welcome addition to the diverse initiatives already being undertaken by medical schools to support student wellbeing. The online MHFA course teaches students how to assist a peer who is developing a mental health problem such as anxiety, depression or substance abuse, or is experiencing a mental health crisis.

Medical Deans collaborated with the Australian Medical Students Association (AMSA) to advocate for Government funding in 2019, and the Department of Health worked quickly following the onset

¹⁴ *The challenges international students enrolled in a medical program and currently located offshore remain. Some medical schools have continued with preclinical studies online and others have required offshore students to defer.*



of the pandemic to contract Medical Deans to administer funding for students in Australia's 21 medical programs to undertake online MHFA training in 2020 and 2021. Medical Deans also partnered with AMSA to promote the MHFA training to students. Student feedback on the course to date has been highly positive.

3.3 Challenges

Training doctors to work in multidisciplinary teams

Speaking to the 2020 MDANZ Annual Conference, the CEO of St Vincent's Health Services, Toby Hall, predicted that the rapid uptake of telehealth would be the most important change to the health system due to COVID-19. The second would be the use of technology to deliver health services in the home. Both changes would steer medical practice further towards work within multidisciplinary teams, with members working more consistently to the top of their scope of practice.

Mr Hall shared the example of a team comprising five clinicians from different professions delivering an ICU-equivalent hospital-in-home service, early in the pandemic, to a 92-year-old patient who had never used any form of telemedicine before. "The team was able to do in 20 minutes what would normally have taken four days to do. The patient was also very happy with the service."

The challenge for medical educators is to determine how telehealth and other technological healthcare model disrupters can best be reflected in the delivery and content of medical training for doctors of the future. "As we go forward a lot of clinicians will be asking, 'how do I upskill other people to do some of the things I would have done in the past, so that I can focus on the highest level of my skill and let them focus on the highest level of their skill?' That is going to need thought and training," Mr Hall said.

Reducing reliance on IMGs

Australia and New Zealand both rely heavily on International Medical Graduates (IMGs) to support shortages in their national medical workforces. In Australia, IMGs made up 41 per cent of the medical workforce outside of major cities in 2018¹⁵ and represented approximately 30 per cent of new fellows in psychiatry in 2019¹⁶. A similar reliance on overseas doctors exists in New Zealand, where IMGs made up 40.4 per cent of the medical workforce in 2019¹⁷, with 52.9 per cent of these IMGs working in rural areas¹⁸. The closing of national borders due to COVID-19 exposed the fragility of this model and the need for Australia and New Zealand to build more self-sufficient national medical workforces that are less exposed to global shocks, particularly in areas of workforce need. This has been included as a stated aim of Australia's (Draft) National Medical Workforce Strategy.

How we select, teach, support and enable our future doctors must align with this need for greater self-sufficiency. Clinical exposure and experiences should positively reinforce the learning achieved through medical school, encouraging students and graduates to pursue career opportunities aligned to population health needs, whether in certain geographical areas or in medical specialties in short supply (e.g. general practice, psychiatry). We must also address the 'hidden curriculum' where systems preference and promote city-based and sub-specialty careers.

¹⁵ Australian Institute of Health and Welfare (2018) *Australia's Health 2018 – Chapter 2*, page 67.

¹⁶ Australian Government Department of Health (2020) *National Medical Workforce Strategy Scoping Framework*, July 2019.

¹⁷ *The New Zealand Medical Workforce in 2018*, Medical Council of New Zealand, p.4.

¹⁸ *Ibid*, p.34



As the first stage in the medical training continuum, medical schools must help drive policy change that supports graduates to undertake their internships and postgraduate training in regional and rural settings, and within specialties that support population health needs. Placements in medical school are an important first step in this pathway, but the exposure must continue in post-graduate training for the sector to achieve the desired workforce outcomes.

What we want to take forward

- Strong collaboration between medical schools and across the training pipeline: on issues including assessment, transition to practice, good practice use of technology, advocacy on education and health workforce policy
- Increased partnerships with students, including co-design of student support initiatives and advocacy on support for student health

The ongoing challenges

- Training doctors of the future to work in multi-disciplinary teams
- Over-reliance on IMGs to fill medical workforce shortages

CONCLUSION

The picture which emerges from one of the most challenging years on record is a one of medical schools working in stronger partnerships – with each other, with students, with health services, with postgraduate training, with regulators, and with governments – to ensure students were able to progress through their course despite the disruptions and uncertainty.

It is recognised that this came at a great cost, both financially and personally, to those involved: curriculum designers, assessors, educators, student support leads, clinical supervisors, leaders and not least, students. And the long tail of COVID-19 continues to sting, even in Australia and New Zealand, where the impacts have generally been less severe than elsewhere. The impacts of lockdowns are significant – on peoples' health and livelihoods,

Medical educators want to build on the changes and collaboration experienced during 2020 in all the ways highlighted in this report. We seek to embed and further strengthen our partnerships, shared commitment, and reciprocal support. We strive to provide the leadership, courage and rapid decision-making that helped us get through the early stages of the pandemic.

Medical Deans is committed to keeping the focus on the lessons learned during the first year of the pandemic, and leveraging this opportunity to change for the better so that we don't let slip the benefits already gained and are able to realise those on offer.



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