International Trends in Medicine and Health Professions’ Education: From Policy to Practice

Professor Judy McKimm
Dean of Medical Education, Swansea University, UK

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Outline

• Context
• Policy and service drivers
• Current trends, international influences
• Challenges, strategies and ideas
• AusAID project in the Pacific Region
• Where next?
Health professions' education
Changing healthcare and education contexts
Universities and regulatory bodies

- Quality Agencies
- Medical Councils
- University QA requirements
- National standards, rankings
- Student and employer evaluations
- Preparation for postgraduate training
More regulation, quality monitoring and assurance?
Policy and service drivers

Globalisation of Higher Education and students’/professionals’ migration patterns

Medical schools expanding into new countries (Malaysia, Cyprus, US)

“academic imperialism”

Financial drivers – higher fees, international students; higher unemployment, more studying, capping of numbers tied to performance indicators
Policy and service drivers
Higher Education

**Modularisation** of programmes

**Bologna process** – aims to ensure comparability in the standards and quality of higher education qualifications in European Higher Education area

**Global responses to Bologna** – in 2007 joint declaration between EEHEA and Australia, rapid convergence of the education systems. In January 2013, Macquarie University first to align degree system with Bologna Process
Policy and service drivers: HE

- Shift to initial/basic degree-level professional qualifications
- Changes in student numbers
- Links to local/national workforce commissioning
- International student flow increasing
- New ways of learning/teaching
- Changing expectations of students (Gen X, Y, me)
Changing nature of degrees

Graduate entry – in some professions/countries (eg medicine in US) entry to basic undergraduate education is limited to graduates.

In other countries (eg. Australia) a shift to masters’ level professional training is occurring.
Policy and service drivers
Health and social care education

- Many studies say graduates aren’t practice-ready
- Tensions with crowded curricula
- Changes in post-qualifying training ... a shift to generalism?
- New roles, dually qualified practitioners, extended and expanded scopes of practice
- Patient and service user involvement
Service shifts

• Integrated, patient/client-centred services
• Move to community based services and ‘centres of excellence’
• Mobile and personalised technologies
• Economic constraints and staffing shortages
• Different regions need different services
Social factors

• Ageing population
• Dispersed families/communities
• Increase in long-term conditions
• Technology use increasing (assistive technologies, hand held diagnostics)
• Increase in patients managing own conditions
• Feminisation of medical workforce
• Rural and remote areas often under-resourced
Pacific HRH project

• AusAID funded project
• Provide evidence and options for medical/healthcare education strategy for the MoHs of Pacific Islands, Countries and Territories (PICs)
• Led by UNSW Knowledge Hub with international team
Geography
Drivers for change

• Achieving MDGs
• Variable access to healthcare, especially in remote areas/islands
• Different systems in PICs – lack of integration
• Low numbers of doctors, particularly specialists
• Reliance on outsourcing care
• Cuban trained doctors returning - assimilation
Key areas

Integrated health system across PICs

- Medical education and training
- Commissioning education
- Accreditation
- Regulation and licensing
- Extended & expanded roles
- Internship
Medical education and training

• Align scholarship, commissioning systems and workforce planning
• Align undergraduate medical education and postgraduate training with workforce planning, within and between PICs
• Curriculum models (e.g. graduate entry) to enable career progression into medicine for other health professionals or for new roles
Medical education and training

• Common training standards, outcomes and competencies across the region (the ‘Pacific doctor’)

• Emphasis on non-communicable diseases (NCDs) and reinvigoration of primary health care, experience of specialities/topics (e.g. tuberculosis, malaria) and contexts (e.g. primary/remote health care).

• Curricula, teaching and learning methods and assessments enable achievement of the defined outcomes at key stages of medical education and training
Medical education and training

• Program accreditation, regulatory and licensing mechanisms reflect international best practice
• Minimum professional standards to facilitate mobility to practice in areas of need
• Common scheme of PG training, structured internships and speciality training programs
• Regulatory and licensing systems define scopes of practice re other HPs and facilitate assimilation of overseas trained doctors
Internship

• Phase of medical training following graduation
• Supervised practice while learn to apply knowledge, practise skills and take increasing responsibility for patient care
• ‘Pinch point’ in Pacific for locally trained (public and private) and overseas doctors
• Poor or variable training programs, no defined curriculum or length of training, disjunct between internship and specialty training or CMO posts
Internship

- Need one internship model across the PICS – e.g. core+options; shorter internship->general residency etc
- Defined curriculum with competencies and outcomes, trained supervisors
- Same standard for locally and OS trained doctors – use internship program as ‘bridge’ for OS trained graduates as part of assimilation into workforce
- Share access to internship programs/rotations across PICs
Commissioning

- Scheme and processes by which education and training programs (and numbers of students in programs) are funded and assigned to healthcare education and training organisations
- Includes allocation of state- or donor-funded scholarships, subsidies and self-funding schemes
- Typically involves formal quality assurance of the education and training provided
Commissioning – international evidence

• Commissioning (and funding) needs to be aligned to workforce planning, registration/licensing and regulation
• Scholarships etc can skew the process
• Tensions between public and private providers
• Whole workforce approach needed
Accreditation

• Quality assurance process that evaluates educational/training institutions, programs and practices

• Determines whether applicable (i.e. national and/or international) standards for healthcare professionals’ education are met

• Different models: national, professional, regional, international
Accreditation

• Educational programs – internal and external review and processes needed, to defined standards/benchmarks – raise quality
• Shift to HEIs self regulation and external QA of processes
• Accreditation can facilitate mobility between programs, professions and countries
• Needs to be linked to health needs and WF planning – standards/outcomes tailored to meet country needs
Regulation and licencing

• Regulation from graduation and throughout careers, typically through initial awarding and subsequent renewal or extending of licence to practice

• Guarantees quality of workforce (fitness for purpose) and quality and safety of care (fitness for practise) against agreed external standards

• Two broad models/types
  – achievement of educational qualifications/certification and/or
  – passing national or regional examination(s)
Regulation and licensing

• All HPs need to be regulated, registered and licensed
• Common model and system needed across PICs to ensure parity of standards and easy movement between PICs
• Clear definition of standards for overseas trained HPs, matched to internal standards (includes reciprocal agreements where relevant)
• Linked to workforce planning and flow and commissioning – control of WF e.g. at initial licensing, training programs
Extended and expanded roles

• Expanded and advanced healthcare practitioners’ roles go beyond customary doctor–nurse–midwife models

• Terminology varies, include Physician or Medical Assistants, Nurse Practitioners, Health Extension Officers, Clinical Nurse Specialists (CNS) drawn from health professionals with extended scopes of practice
Extended and expanded roles

• Can provide a better, accessible model of care e.g. in rural/remote areas
• More efficient use of health workforce
• Care provided shown to be as good as doctor led service
• Training needs to be tailored to country/region/organisational need and regulated – scope of practice guidelines, supervision, CPD
• New career pathways needed, job roles and conditions need to be clear
Summary

• Whole workforce approach is way forward – but difficult to implement across all PICs
• Purpose of workforce strategy needs to be clear – from commissioning through to specialty training/CPD
• Medical and health workforce migration is key driver for change
• Doctor-led healthcare not always best or possible
• Mixed model enables flexibility with clear fundamental principles aligned to international standards and practices
Implications for education

• More transparency about learning outcomes, criteria, standards, measures
• Preparing students for changing services and a global world
• Training for teachers (and learners)
• Responding to changing technology and learners’ expectations
• Robust, integrated data management systems
• Physical locations? Cloud and virtual worlds
Admissions and selection

• “the first assessment”
• Shift towards more reliability and validity
• Away from interviews and ‘open space’
• Multiple Mini Interviews, Situational Judgement Tests and Assessment Centres
• Are we selecting in or weeding out?
Curriculum

• Curriculum content more open source
• Shared resources – Open Educational Resources
• Flexible, agile curricula
• Think global, act local (Lancet Report, 2010)
• Undergraduate courses must link in with postgraduate training reviews
• More community based learning
• More collaborations, franchises
• Internationalisation
• More generalist OR more early specialisation
• Changing nature of knowledge and evidence
• Location of ‘the curriculum’ – Cloud
• Shift to directed self learning
• More tailored, more personalised
Assessment

Assessing things differently

– Shift towards national assessments
– Technology enabled assessment
  • Eportfolios; wikis and blogs; social networking; tablets/smart phones
– Simulation
– Workplace

Assessing different things

– Teamworking - “the giving, seeking and receiving of performance-related information between the members of a team” (Dickinson and McIntyre, 1997)
– Professional behaviours (multisource feedback)
• Timetable feedback opportunities formally into the curriculum
• Flag up to students when they are getting feedback – students often say they don’t get enough feedback, especially on exams
• Feedback needs to be timely
• Structured, tailored feedback valued by students
More than just assessment

Academic – Fitness for purpose

- Formal assessments linked to curriculum learning outcomes
- Written - understanding e.g. of professional guidance, law/ethics, communication
- Practical – OSCEs, skills tests
- Clinical practice – placement supervisor’s assessment, MSF

Professional - Fitness to practise

- University disciplinary e.g. drinking, theft, plagiarism
- Programme level – lateness, attendance, general poor behaviours – student concern form, monitor attendance, MSF
- GMC - all of the above plus health for practice, patient safety
Pendulum swings

- Assessment of learning
- Assessment for learning

- Global assessments/profiles
- Competency based standards

- Regurgitation of knowledge
- Able to seek and appraise knowledge

- Assessment of professionalism
- Behaviours require support or sanction
“From support to sanction”

- Integration between systems and processes for admissions, assessment, student support and Fitness to Practice/Disciplinary
- ‘Early flagging’
- ‘Web of support’ across all locations
- Embedded time in curriculum for feedback, review and debriefs
Swansea - Integrated Student Record (ISR)

• Brings all information together
• Students ‘at risk’ are supported, flagged early
• All students have formal mid-year appraisal where structured feedback on all elements of performance is given and action plan made
• Issues flagged for Progress & Professionalism team or other support (disability, health, diagnostic, academic writing study skills)
Profiling

• Identify criteria spanning all aspects of learning/activity
• Establish key data gathering milestones (includes formal assessments)
• System pulls information into personalised profiles – monitoring
• Benchmarks set for ‘red flags’ – processes
Workplaces, communities and the ‘global village’

- Patient pathways: breaking boundaries between primary and secondary care
- Apprenticeship learning – modern apprenticeship, real life learning
- Reorganise clinical placements to enable more early workplace based learning
- Social accountability – collaborations with low resource countries
Technologies

• Mobile learning
• MOOCs - ‘Open source’ curriculum and assessments – seeking and appraising, not just remembering
• Personalised, tailored programmes, self assessments, feedback and profiling
• Cloud based, big data, evaluation and research
• Simulation, virtual worlds, gaming
Integration

• Not just curriculum integration
• Integration between universities, hospitals and community activities
• Systems and process integration
• Content management systems: underpin curriculum assessment and evaluation
Balancing act

- Communities vs individuals
- Collaboration vs uniqueness
- Training vs education
- Workplace vs university
- Research vs teaching
- Service needs vs learning needs
- Art vs science of medicine/healthcare

- Technology as an enabler and not a driver
In summary

• Technology will enable more than we can dream of
• Driven by workforce/health needs, not what is educationally possible
• “Think global, act local” – global health workforce
• Integrated systems are essential
• Collaboration, sharing practice, achieving goals

“change is the only constant”
Thank you!
Any questions?

j.mckimm@swansea.ac.uk