

SHORT COMMUNICATION

A proposal for funding and monitoring medical education supervision in expanded clinical settings - a 'meducation' card

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ABSTRACT

Context: Entry to practice medical programs (graduate- and undergraduate-entry) in Australia are under considerable pressure to provide clinical training as a result of increased student numbers. At the same time modern medical curricula require the development of active placements in expanded settings to achieve graduate medical practitioners who are clinically able. These dual imperatives require a mechanism to fund and maintain the quality of clinical placements outside the traditional hospital setting.

Issue: For teaching outside traditional teaching hospitals the Australian government's Practice Incentives Program (PIP) currently provides a student-related payment of AU\$100 for each half-day teaching session in a general practice setting. This payment is not linked to the quality of the placement and does not support clinical placements in other settings, for example specialist consulting rooms or allied health practices.

Solution: This short communication proposes a 'meducation' card as an efficient funding mechanism to facilitate an expansion of quality clinical placements in expanded settings including specialist and allied health practices. This student meducation card would use current Medicare Australia infrastructure to facilitate the payment of clinical teachers in expanded settings. Meducation payments would only be available to practitioners and practices that maintain quality teaching practices certified by medical or allied health schools.

Key words: Australia, clerkships, clinical placements, funding, medical education, practice incentive payments, teaching payments.



Context

Entry to practice medical programs (graduate- and undergraduate-entry) in Australia are under considerable pressure regarding clinical training placements as a result of increased student numbers¹. Coincidentally, medical curricula are focussing more on meaningful, active clinical placements in expanded settings to achieve graduate medical practitioners that are fit for purpose. These dual imperatives require a mechanism to both fund and maintain the quality of clinical placements outside the traditional hospital setting.

Issue

The teaching incentive component of the Australian government's Practice Incentives Program (PIP) currently provides a student related payment of AU\$100 for each half-day teaching session in a general practice setting². General practices are paid retrospectively only if specific paperwork is filed and approved by a medical school. Payment is not specifically linked to the quality of the placement or supervision per se. Importantly, clinical placements in other settings, such as specialist or allied health professional consulting rooms, remain unsupported. The Council of Australian Governments (COAG) initiative Health Workforce Australia (HWA) is currently developing programs to support clinical placements in a wide range of health professional disciplines including medicine. The HWA has emphasized the importance of increasing the capacity and quality of clinical placements to build a larger and more effective health workforce³. One principle in this debate is that funding should follow the student and be linked to the quality and effectiveness of the placement.

Solution

A proposed solution is the development and use of a 'meducation' card to achieve this aim. The meducation card would be issued to each medical student for use during their entry to practice clinical training and would be linked to their

registration with the Medical Board of Australia. The card would use the current Medicare Australia infrastructure (available in general practices, and in specialists' and allied health professionals' consulting spaces) to allow educational item numbers to be claimed for the supervisor. Educational item numbers would include supervision for a fixed period of time and provision of tutorials or case conferences, but might be expanded in the future to include funding for services provided by a senior student. In order to ensure quality, practices and/or supervisors would need to be accredited by universities in order to claim for clinical supervision. The card would include smart card technology to limit the total payments related to a particular student.

The implementation of the meducation card would immediately simplify the funding processes and improve timelines of payments related to medical student clinical placements in general practice. These might increase the number and geographical spread of available places. In addition, it would provide a mechanism by which the quality of the supervisor and placement site could be linked to funding by ensuring that only claims from accredited supervisors and sites would be processed. The nature of this accreditation process would need to be developed; however, a recent series of workshops run by HWA suggests that national standards are already under consideration⁴. The implementation of meducation card would also facilitate the development of clinical placements in new settings such as private specialist and allied health professional consulting and treatment rooms. This would significantly increase the opportunity for medical students to gain clinical exposure to patients with chronic diseases or acute problems not seen in hospitals. The card would also assist in a process to track students and their placements outside the hospital sector, but if successful, placements in the hospital sector and for other health professions students (ie nursing and allied health) could be included in the meducation card program with similar requirements for quality outcomes. For these and other reasons, the meducation card system would have distinct advantages when used in rural medical education in both regional and remote sites (Fig1).



- A student is assigned to a year-long continuity rural experience based on a set university curriculum. The curriculum requires both general practice and allied health rural placements related to aged care. In the past, each provider might invoice the University or the GPs would claim PIP payments, which would be made quarterly or semi-annually. However, given the increase in student numbers in the region, the health service, frustrated by provider burn-out, overtime claims, and delayed (or not) payments with long client waiting lists, has recently sent a letter to providers and universities stating that there is no further capacity for placements with hospital in the home. This student's 'meducation card' is pre-programmed with 50 sessions of access to health -provider settings over the semester. At each university-approved site, the student swipes their card in the 'Medicare' card system and payment is transferred electronically. The decrease in paperwork submission frees up time for more clinical teaching sessions with students in the region.
- A half-day session with a rural urologist, gynecologist, or pediatrician in their private rooms is part of a community-based rotation. The 'meducation card' payment facilitates an extra room for the student who can see the patient before and with the specialist (eg rather than the room being rented to another provider). The next week the student comes to the rooms to spend time with the associated continence nurse, midwife, or pediatric physiotherapist (the specialist is elsewhere) and a 'meducation card' session is charged. Each session includes a brief discussion with the student about learning issues encountered over the session. Over 4 weeks the student has 'spent' 4 sessions (each with a different provider) and has been an active part of the clinical experience. Compare the potential of this experience with the student 'sitting in' with these providers for sessions that are heavily booked.
- A visiting dermatologist flies into a remote Aboriginal Health Service where a medical student and a nursing student are completing a rotation. Both students attend the day with the dermatologist and 'spend' 2 'meducation card' credits. The payment to the dermatologist means that they are willing to set aside an hour for a formal teaching session on lesion removal and wound repair in addition to discussing the cases seen by the group that day.
- A rural visiting rheumatologist usually supervises medical students based on university position funding but must keep up productivity in their private clinic due to the costs of room and staff hire. Based on a 'meducation card' payments from a rural physiotherapy student and a rural medical student, the rheumatologist is willing to decrease their patient bookings slightly to accommodate both students and facilitate an interdisciplinary case review during that time.

Figure 1: Examples of applicability of a 'meducation card' in rural settings. PIP, Australian Government's Practice Incentives Program.

Finally, using pre-determined numbers of funded clinical training sessions would allow forward budgeting based on total student numbers. Although some might argue that a potential disadvantage of the meducation card would be an increase in the total cost of clinical placements because new settings and more supervisors would be involved; however, assuming that teaching cost and remuneration follow the student, the total number of students will determine the cost of training, regardless of mechanism. Considering the current increase in demand for these placements this may not be a major disadvantage, particularly if the payment is clearly linked to a quality outcome for the students. A 'point of education' payment model might also be the subject of fraud but this is probably no greater risk than with the entire Medicare system.

The effective education of the next generation of medical practitioners will continue to have challenges but the relatively simple implementation of the meducation card would facilitate a new era of expanded setting clinical placements in a quality framework – something well worth considering.

References

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