Review of Medical Intern Training Discussion Paper
Written Submission Template

The Review of Medical Intern Training has been commissioned by the Council of Australian Governments (COAG) Health Council to examine the current medical internship model and consider potential reforms to support medical graduate transition into practice and further training.

A discussion paper has been released as part of the initial consultation process for this review. This template provides organisations and other stakeholders with an interest in the Review the opportunity to provide written comments and feedback on the matters raised in the discussion paper. Questions raised in the discussion paper are listed below as a guide to responses.

Submissions are due by close of business **Friday 10 April 2015** and can be addressed to:

Medical Intern Review
C/o NSW Ministry of Health
Level 8, 73 Miller Street,
NORTH SYDNEY NSW 2060

To provide a written submission please complete this template and e-mail to medicalinternreview@coaghealthcouncil.gov.au.

Please note: electronic submissions are preferred.

The discussion paper on which this submission template is based is available on the COAG Health Council website: www.coaghealthcouncil.gov.au/medicalinternreview

If you require any further advice or assistance please do not hesitate to contact the Review Team on medicalinternreview@coaghealthcouncil.gov.au or 02 9391 9708.

Publication of Submissions

It is intended that submissions will be made publicly available as part of the review process. Please indicate if you would **not** like your submission to be made public:

Please tick if you do not want your submission to be publicly available

Stakeholder Details	
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Term of Reference 1: Purpose of internship and whether current model remains valid and fit for purpose

Discussion Points

1. What is the purpose of internship, given that independent practice as a medical practitioner is now only possible after a minimum of 4 years of vocational training?
2. Is internship in its current form fit for purpose? Should the current model change? How should it change?
3. Is the training component of internship able to be separated from the clinical work role?
4. If the internship should continue largely as is, are there any changes that could improve this model?

1. Purpose of Internship

Internship is part of the career development continuum for doctors. It should not be seen as a stand-alone year, but merely one step in the medical education continuum. It provides foundation skills for transitioning from the role of a medical student to that of a medical practitioner in the following ways:

i. Undertaking the initial transition to "being" a doctor in a complex system, and dealing with uncertainty and ambiguities of patient care in real time;
ii. Taking responsibility for safe patient care and medical practice under levels of supervision and autonomy commensurate with levels of assessed competence and confidence
iii. Development of professional identity as a doctor including building adaptive skills and clinical reasoning
iv. Learning to work as part of healthcare system in service delivery teams, through reinforcement of professionalism, and role modelling leadership

2. Fitness for purpose

As has been noted in the Discussion Paper, internship was initially designed for a different purpose - to achieve general registration, which allowed for independent practice. However, as the health system has evolved including placing a greater emphasis on patient safety, there have been concomitant changes to internship that support the purpose outlined in our response to q.1. If the purposes for internship that we have listed above are accepted, than we contend that the current internship system does serve its purpose. However, there is scope for some changes that we outline later in this section.

In making the internship system responsive to the changes in the Australian healthcare system, it is important not to underestimate the substantive incremental improvements to prevocational medical education and training made by Postgraduate Medical Councils, These include robust accreditation as a marker of quality assurance; dealing with significant increase in numbers of graduates taking up internship; increased educational and welfare support for junior doctors; the widespread dissemination of the *Australian Curriculum Framework for Junior Doctors* (ACF); supporting expansion of internship into non-traditional

settings; and increased support for teachers and supervisors of prevocational trainees.

CPMEC is mindful that there have been anecdotal claims about the fitness for practice of medical graduates. However, there is little robust evidence to support those assertions. The reality is that most medical graduates are a highly motivated and high achieving cohort that would meet the requirements of any performance management system. Whether the current assessment model is valid and reliable in assessing the purposes of internship as outlined earlier is obviously a moot point and will require further investigation.

It is to be noted that feedback from our various junior doctor forums indicate a very positive view of the current system and it allowing them to transition into the healthcare system. However, that has to be balanced against a lack of exposure to other models.

3. Training and clinical separation

CPMEC believes that if terms are well-structured and accredited, the education-service dichotomy is largely artificial. In any case, trying to separate training and clinical work roles would undermine one of key tenets of internship which is transitioning to work-based learning and undertaking tasks in real time under appropriate levels of supervision. Part of the journey towards independent practice requires development of the ability to identify tasks within one's level of competence from those for which support is required. This requires close liaison with immediate workplace supervisors.

In theory, one can use learning aids such as high-fidelity simulations to complement and make teaching more efficient but it cannot ultimately substitute for actual work experience.

4. Scope for changes

CPMEC would be concerned if there was a decision made to dispense with the formal internship year and not replace it with any other structured curriculum-driven programme with specific objectives and outcomes. The challenges of undertaking educational activity in largely service environment are considerable and one should not underestimate the impact of these "education-service" tensions including protected teaching time in hospitals at the PGY1, if general registration requirements are removed. In this regard, there should be consequences for health services if terms do not meet accreditation standards.

CPMEC would like the Review to consider the following changes:

i. Having longer terms of up to 13 weeks as a minimum to help the transition to a healthcare system. There are already longer terms in some Australian hospitals. It may be useful to consider whether longer- terms would provide a more robust basis for work-based assessment of skills including teamworking, professionalism, etc.by supervisors and non-medical staff as well. We believe that the benefits of longer rotations would also increase service value of trainees and would outweigh any loss perceived by trainees in the educational value of sampling shorter rotations.
ii. Ideally, CPMEC would like all trainees to be exposed to non-acute healthcare settings to broaden their scope of their experience and practice of the Australian healthcare system.
iii. Revisit the requirement for mandatory rotations in surgery and medicine. Systems similar to Australia such as the United Kingdom and New Zealand have moved away from mandatory rotations but both have clearly defined learning outcomes in place through a curriculum (In this regard, it pertinent to note that the Medical Council of

New Zealand have based their work on the ACF).

In making changes to internship, we would emphasise the need for all relevant stakeholders to work closely with prevocational medical education bodies at the national and state levels to design and implement any reforms. It is also important that any changes to system must be preceded by broad consensus on the purpose and expected outcomes.

Term of Reference 2: Effectiveness of the intern year in producing doctors with appropriate skills & competencies to meet national healthcare needs and support generalist practice

Discussion Points

5. Is the intern year effective in building and assessing the skills required for future practice, both general clinical skills and professional skills?
6. Is the duration of internship sufficient to enable effective transitioning into clinical practice?
7. Does the variation in clinical exposure of the current intern model matter?
8. Should all interns have rural, general practice, private health and/or community based experience during their internship? Why?
9. Do the mandatory rotations in fact provide the experience in their nominal specialties? Should all interns do a surgical term? A medical term? An emergency medical care rotation? Should other rotations be mandatory?
10. Should we consider streaming directly into specialty or GP training? What implications and opportunities would this have for service delivery and length of training?
11. To what extent does internship training prepare doctors for emerging models of clinical practice and for vocational training?

5. Effectiveness of the Intern year

In the absence of any robust evidence, it is difficult to provide a definitive response to the question. This is more so when one considers that the internship year is basically the first year in the postgraduate career journey of a medical graduate. It is quite arbitrary to take the end of the internship year as the point to assess whether the trainees have acquired the necessary general clinical and professional skills. The internship year provides a baseline of general skills and knowledge that all junior doctors possess that can be supplemented by terms in other areas of interest. It provides the building blocks for further postgraduate training.

6. Duration of Internship

Transitioning into the health workforce is a process that commences from the day that internship starts. Anecdotal evidence presented about work readiness of medical graduates indicates a degree of variability with some trainees needing a longer period of consolidation than others. However, current assessment processes indicate that most are able to transition into clinical practice during the internship year. As noted earlier, given the changed purpose of internship, there may be a need for more robust work-based assessments to gauge the effectiveness of this transition.

7. Variations in Clinical Exposure

Robust accreditation of intern terms (including completion of mandatory terms) effectively serves to moderate variations in clinical exposure currently. However, some variations are inevitable as health systems respond to changes in healthcare environment and these will have impact on learning experiences. The development of a robust curriculum, with clearly defined and expected outcomes, would help to address the issue of variations in exposure.

8. Rural, GP, Private and Community experience and rural exposure

As highlighted in the Review Discussion paper, there have been significant structural changes in the organisation and practice of healthcare and interns should be exposed to these changes. We would support all interns having wider exposure in non-acute settings but need to ensure that the experiences are educationally meaningful, trainees are supported and supervised, and some account is taken of the different stages in personal and family life cycles of the trainees. As mandatory requirements in this regard are unlikely to be logistically possible, it is also important not to block out opportunities for those who are really interested and motivated in doing these terms.

9. Mandatory rotations

CPMEC does not believe that mandatory rotations continue to provide the experience they were designed for historically given the vast changes in medical practice including the significance of general registration. Some cognisance should also be taken of the fact that mandatory terms may bias career decisions towards terms that have structured training sessions and away from those with less exposure and visibility.

As noted earlier, it is important is to have a curriculum outlining key capabilities that an intern is expected achieve irrespective of where they are allocated a placement. The *ACF* as a tool is designed to support this but will require more work in defining clearly assessable outcomes. An electronic portfolio to record experiences and facilitate assessment would aid this process. CPMEC recognises that moving away from mandatory rotations may be contrary to the views of most junior doctors and medical students.

10. Early Streaming

CPMEC supports the current focus of the intern year to acquire a suite of generalist skills and to avoid specialty silo thinking from the outset of postgraduate training. If mandatory rotations are no longer a requirement as suggested above, this may allow junior doctors greater flexibility to develop career plans from an earlier stage in their postgraduate journey. We would suggest that personal career planning should be seen as an integral part of the performance review of interns.

In terms of impact on duration of training, this will clearly depend on the extent to which vocational training colleges have systems and the willingness to recognise the prior learning experiences of trainees entering their programs. A further point to note with regard to early streaming is that there should not be a perceived penalty associated with broadening one's generalist experience as the "early streamers" are allocated the most attractive vocational training posts.

Should a direct streaming option be contemplated, there may need to be retraining opportunities for those who get into a stream that they realise later to be a poor fit with their career aspirations and aptitudes.

11. Preparation for Emerging Models of Clinical Practice and Vocational Training

To a large extent, intern exposure to emerging models of clinical practice would be tied in with their transition into the healthcare system. As one would expect there would be a degree of variability in the exposure to the models of care based on the health contexts in which they are located. With regard to preparation for vocational training, as noted earlier internship is some ways provides a broad base for further training. The challenge for colleges is to build on this base.

Term of Reference 3: The role of internship in supporting career decision making by doctors

Discussion Points

12. How important is it for the general registration process to support doctor's career decisions, including specialty or location of practice?
13. Are there alternative ways to facilitate such career decisions if the structure of internship was to change?
14. Can or should the internship system be a mechanism for attracting doctors into specialties/locations of workforce need?
15. From a careers point of view what might be the risks and benefits of early streaming?

12. General Registration and Career Decisions

The nexus between general registration and career decision making is unclear. General registration is basically designed to certify that the intern is safe to practice within the limits of their training. In completing internship as part of the general registration process, one of the intended benefits is that exposure to the different medical specialties may help shape career decisions. However, there is no overt link between achieving general registration and choosing a career path.

13. Facilitating Career Decisions

At the outset, it is important to differentiate between those graduates who have decided on a speciality and those who wish to experience some dwell-time before crystallising their career paths. Both pathways produce highly capable independent practitioners in Australia and CPMEC is of the view that a flexible system would cater for needs for both categories of doctors. There have been some suggestions that we are increasingly dealing with medical graduates with different levels of preparedness and maturity but whether this translates into greater clarity about career pathways is unclear.

Facilitating career decisions requires clarity on the information needed by trainees to help make informed and realistic decisions. Competition ratios, success rates, and likely employment prospects are just some of the information that could be useful to interns (and medical students). CPMEC has considered this to be a high priority in prevocational medical training and has brought together all key stakeholders to address this gap. We would be happy to share the work we have done to date with the Review Team.

14. Internship as Workforce Policy Lever

CPMEC notes that the method of appointment to intern positions is outside the scope of the

review. However, if internships were to be used as a policy lever, there would need to be a move away from merit-based allocation systems that favour placing the best trainees in the most attractive major teaching hospitals and the unintended consequence of those ranked lower having the least attractive postings in outer metropolitan and regional centres.

However, other than supporting intern rotations into non-acute settings, CPMEC is of the view that there is limited scope to use internship as a workforce policy lever, as the real benefits are likely to accrue at the vocational training level as the trainees undertake more unsupervised work. It may be better to provide opportunities for those interested in undertaking terms in areas of workforce need.

15. Early Streaming

As noted in our responses to q.10 and q.13 above, the greatest risk would be a reduction in the flexibility that the current system provides.

Term of Reference 4: Models to support expansion of intern training settings

Discussion Points

16. What models might be viable to expand intern positions beyond the largely public health system model we have today?
17. How could/should internships in the private and community sectors be funded and supported?
18. Would there be value in linking availability of a paid intern year to a subsequent year of service in an area of workforce need?
19. What options could be considered to fund training opportunities for medical graduates?

16. Models to Expand Intern Positions Beyond Public System

CPMEC notes that there have been attempts to expand internship beyond the public health system and jurisdictional submissions will have highlighted this. The Prevocational General Practice Placement Program (PGPPP) was a good initiative in this regard and it was disappointing to see it scrapped by the current government.

CPMEC sees the need for internship to be responsive to community needs whilst simultaneously addressing the professional development needs of the next generation of doctors. Developing a sustainable model in the current context that allows doctors to undertake internships beyond the public system will require a collaborative private-public partnership suited to local circumstances. One of the impediments to expanding internship in the private sector is meeting accreditation requirements including the establishment of the educational infrastructure and having the supervisory requirements to host an intern. Providing that equitable funding arrangements can be put in place, a partnership may help overcome the process by allowing more private sector facilities to host interns in partnership

with public hospitals which would act as the lead institutions.

17. Funding and Supporting Internships in Private & Community Sectors

One approach to consider is designating a component of the salary of an intern as a training and education allocation that would follow the trainee to the health service hosting the intern. Where there are partnerships, there will obviously need to be agreement on how the training grant would be shared. CPMEC recognises that given the federal, state and territory involvement in the various phases of internship currently, funding issues take on additional complexities.

18. Return on Service Obligations

There could be some merit in terms of exposure if the programs are designed to cater for the needs of this group but CPMEC is of the view that it is unlikely to have major impact at the intern level. Any adverse experiences are likely to be highlighted by the trainees, further stigmatising what are usually less popular postings. It would be better to send trainees who are interested in going there. Furthermore, setting up and maintaining the necessary infrastructure and logistics would be very significant as was evident from the PGPPP initiative.

19. Fund Training Opportunities for Medical Graduates

CPMEC believes that internship should continue to be a paid role but allow for greater flexibility for trainees to undertake it in a range of healthcare settings. Internship must be viewed by all stakeholders as a critical part of the investment into the development of the medical workforce of the future. In point of fact, given that all health services eventually benefit from the public investment internship training, there may be a case for the imposition of a levy on those not contributing directly to the education of the medical workforce.

Other Comments

CPMEC would like to raise the following additional points for consideration by the Review:

20. National Body for Prevocational Training

CPMEC, through bipartisan support and funding provided by successive federal governments until 2014, has played a crucial role in highlighting the need for the prevocational medical training years to consist of high quality educational experiences that are appropriately structured, accredited and supervised. We believe that no other organisation has the experience or the credentials to take on the work that CPMEC currently provides as the profession-led peak body to provide independent, constructive, and informed advice on issues pertaining to internship and prevocational training. In conjunction with our member Postgraduate Medical Councils, we have an extensive (and unrivalled) experience and track record in this field, well established links with all key stakeholders in the profession, and national networks of supervisors, junior doctors and prevocational medical educators. The need for informed and independent advice will become imperative in the next few years as the competition for vocational training places results in trainees spending more dwell-time in the prevocational years.

21. Curriculum

CPMEC reiterates the need for the further refinement of the *Australian Curriculum Framework for Junior Doctors* (ACF) along with the *AMC Intern Outcome Statements* to enhance the quality of learning of interns and make the assessment processes more robust than currently

perceived. The utility of the ACF in this regard is demonstrated by the work done by the Medical Council of New Zealand to strengthen their prevocational training arrangements. To implement the curriculum will require some reorganisation and additional resources to support the supervisors and the medical education team. An electronic portfolio that is harmonised with College and health service platforms would also help in integrating the prevocational phase of training with subsequent postgraduate training.

22. Building Evidence Base

As has been alluded to a number of times in the Discussion Paper, there is little robust evidence to highlight both strengths and deficiencies of the current internship system. CPMEC has long advocated the need to build a stronger evidence base to drive policy. Funding for research into prevocational medical education and training initiatives nationally has been an area of neglect. The demise of Medical Training Review Panel (MTRP) funding since 2007 to undertake research and projects in priority areas in prevocational training has been symptomatic of this decline in support.

23. Implementation

There will be significant culture change issues of any reforms to internship and adequate consultation and implementation time would be required. CPMEC is pleased with the way that the consultation process for this Review of Medical Intern Training has proceeded so far with ample opportunities being given to provide feedback.

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