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. ***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?***

The potential description proposed by the Review of Medicals Intern Training is consistent with the requirements of General Practitioner specialist training.

With respect to the purpose:

> *To consolidate a core set of entrustable activities and the assessment of those within a work environment, as a first step in the progression towards independent practice.*

The intern year provides a critical opportunity to consolidate and assess performance of core activities in a foundation year of practice under a level of supervision appropriate for the level of competency of the doctor.

While the acquisition of core competencies at the end of medical school provides the foundation for doctor performance, it does not necessarily guarantee that this performance occurs.

Competent performance occurs because the separate competencies have been used repeatedly as part of complex professional practice to gather and process information, make judgements and decisions, solve problems, interact with peers, colleagues and patients within a multidisciplinary team and the broader health sector.

This intern foundation year provides a steep learning curve for the consolidation of these sore entrustable activities.

This, of course, occurs within a framework of supervision to ensure patient safety.

With respect to the proposed purpose:

> *To provide a transition to the medical workforce in a system that is safe for patients and for graduates.*

For general practitioner vocational training, one critical purpose of internship is to provide supervised training to ensure that patient safety is maximised as inexperienced doctors perform their professional duties in the general practice setting.

This is especially important for general practice training where patients can present first line in general practice with undifferentiated life threatening illnesses which if undiagnosed, can rapidly result in significant patient morbidity and mortality.

The aim is to ensure the development of competence in the detection and management of serious or potentially serious illness through the full spectrum of the neonatal period, infancy, early and middle childhood and also, where relevant, adolescence and young adulthood before registrars commence general practice training.

For this reason, general practice registrars must have undertaken clinical experience in paediatrics prior to commencement of the first general practice term.

The experience must include a significant focus on the recognition, diagnosis and management of the seriously ill child. In a hospital setting, Registrars are most likely to be able to develop skills in the recognition and management of acute, life threatening conditions and those conditions which, without appropriate management, can result in death or cause severe morbidity. The clinical experience should include a high proportion of paediatric emergency attendances with appropriate supervision from paediatricians and/or appropriately experienced general practitioners and/or emergency physicians prior to entering the first general practice training term.

Not all training in paediatrics can or will be achieved during time in hospital-based paediatric posts. The majority of training and learning will occur during training terms based in general practice. The experience in paediatrics required prior to the commencement of general practice training is to ensure safety in the general practice setting.

It is also important to note that interns and other prevocational doctors training in the general practice setting have a different set of training requirements and supervision standards that for general practitioner registrars. Interns and other prevocational doctors are not expected to have the same level of patient safety skills as general practitioner registrars. This requires a different type and level of supervision.

2. Is internship in its current form fit for purpose? Should the current model change? How should it change?

While the RACGP supports the second proposed purpose of internship

> *To consolidate a core set of entrustable activities and the assessment of those within a work environment, as a first step in the progression towards independent practice*.

However, delineating these core set of activities that meet the needs of all medical specialities can create challenges.

This is easier to achieve in the first year of internships which emphases generalist skills and consolidation core competencies, this is more difficult in subsequent years as prevocational doctors are already selecting career paths towards particular vocational specialties.

The Australian Curriculum Framework for Junior Doctors which covers PGY1 and PGY2, recognises this challenge as it identifies some second year skills as 'Advanced' which may be of little relevance to some vocational pathways.

This issue of a core set of entrustable activities may indicate the need to review the timing of commencing vocational training pathways at an earlier stage than currently occurs, similar to the Canadian model in order to ensure that valuable training experience and resources are cost-effectively allocated to the appropriate vocational training pathways. In the current curriculum framework model, there already appears to be a need for this in the second year, but with future capacity planning, this may even need to occur at an earlier stage of internship.

This also relates to the discussion paper aspect on vertical integration.

In addition, the current emphasis on time based rotations needs to examine the role of an outcomes based focus with a competence framework that addresses the meeting the community service needs for the particular medical practitioner.

3. **Is the training component of internship able to be separated from the clinical work role?**

   See question 1 answer relating core competencies to doctor performance. This indicates how clinical work and training are closely linked.

   Competent performance occurs because the separate competencies have been used repeatedly as part of complex professional practice to gather and process information, make judgements and decisions, solve problems, interact with peers, colleagues and patients within a multidisciplinary team and the broader health sector.

   The intern year provides a critical opportunity to consolidate and assess performance of core activities.

   In addition, an outcomes based focus could potentially offer more benefits in ensuring that core competencies are achieved.

4. **If the internship should continue largely as is, are there any changes that could improve this model?**

   If the system is to continue largely as is, any general practice placements need to be appropriately supported to ensure that general practice has the capacity to manage any community based setting training requirements.

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. Is the intern year effective in building and assessing the skills required for future practice, both general clinical skills and professional skills?

The intern year provides a critical opportunity to consolidate and assess performance of core activities. See answer to question 3.

6. Is the duration of internship sufficient to enable effective transitioning into clinical practice?

See answer to question 2. The current emphasis on time based rotations needs to move towards an outcomes based focus with a competence framework that addresses the meeting the community service needs for the particular medical practitioner.

While time is necessary to develop proficiency in competences, this will depend upon the desired outcome.

The duration of the internship may potentially be tailored more effectively if vocational training outcomes were more closely aligned to specific intern training pathways.

7. Does the variation in clinical exposure of the current intern model matter?

This does impact upon current suitability for general practice training. There are specific requirements for the completion of Fellowship of the Royal Australian College of General Practitioners.

A key issue for entry into general practice is the availability of intern exposure to clinical experience in paediatric management.

The requirement for paediatric experience for general practice vocational training is outlined in the response to question 1.

Applicants to general practice training who lack this opportunity may be potentially disadvantaged in completing their Fellowship.

8. **Should all interns have rural, general practice, private health and/or community based experience during their internship? Why?**

This question would be easier to address in the context of outcomes based curricula for interns.

It one aim of internship was to practice within these settings, then this is an appropriate requirement. However, it should be aligned to the requirements of the training.

With respect to general practice setting, clinicians working for a period of time in community based settings are more likely to have a better understanding of the Australian health system.

All patients receive treatment within a community setting that every clinician will need to understand in order to provide effective services. Therefore, an understanding of the complexities of this setting are an important part of health provider training.

Community based settings have been demonstrated to provide authentic training experience and need to be supported to be able to maximise these training opportunities.

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?**

This question would be resolved in the context of outcome based curricula that focus on foundation year skills as outlined in the Australian Curriculum Framework for Junior Doctors. See the response to question 2 which discusses the difficulty in PGY2 about finding shared common entrustable activities across specialities.

In practice, the intern rotations of medicine and surgery and emergency medicine do provide excellent opportunities for developing foundation clinical skills. The role of more specialised rotations would need to be assessed with respect to the training pathway but could certainly also provide good opportunities for the development of foundation skills.

For example, spending time on an oncology ward can provide an intern with valuable experience in procedural, communication and other professional skill development opportunities entirely suited to the general practice setting. However, the outcomes of each of these positions needs to be matched against the desired outcomes of intern training positions.

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?

This is option worth considering. There is broad international experience that supports this model in terms of efficiency of training. A system could focus skill and performance acquisition more efficiently (not necessarily effectively) than the current system. Intern positions could be more closely aligned with the particular training outcomes of the relevant vocational training path at an earlier career stage.

In the current Australian Curriculum Framework for Junior Doctors, PGY2 skills that may be considered advanced could be initiated at an earlier stage of training if they were relevant to that particular speciality, therefore providing more time for acquisition of that particular competency.

Applicants would need to make their decision about their career path earlier in their career journey. However, as many medical students are now postgraduate students, many have made their career decisions earlier anyway.

The other advantage, is that excluding intern training positions with unrelated outcomes to a particular speciality could maximise the effective use of intern training positions with the opportunity to shorter training duration times and consequent improved training system efficiencies.

The disadvantage, is that many medical graduates will not enter into vocational training pathways, but will move into research, industry and other occupations. In addition, there may be more interns than vocational training positions available. These doctors could be disadvantaged by the requirement of early career specialisation.

One compromise would be to have a mix of intern positions – some directed towards specific vocational training pathways for doctors already committed to a career pathway that incorporate core entrustable activities plus come specialist skills, and some more focused on just core competencies. This would allow variation into entry times into training programs with options for the application of recognised prior learning to maximise training time efficiencies.

11. To what extent does internship training prepare doctors for emerging models of clinical practice and for vocational training?

See answers to questions 1, 3, 4 and 8.

In addition, the emerging models of clinical practice and vocational training are moving towards as competency based, outcomes approach. This may provide a future opportunity for more flexible time duration requirements, and a focus on achieving the professional competencies and performance levels required to meet the relevant needs of the Australian community.

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. How important is it for the general registration process to support doctor's career decisions, including specialty or location of practice?

Supporting career decisions are not a prime function of registration but can expose interns to experiences and specialties that may influence possible future career choices.

13. Are there alternative ways to facilitate such career decisions if the structure of internship was to change?

Workforce programs, education systems and the medical profession have a joint responsibility to attract the best possible candidates to medicine through ongoing promotion.

The adoption of lifelong learning that includes exposure of real-life vocational training experiences to medical students early in their medical training may promote earlier career choice decisions.

These exposures need to be 'hands-on' for medical students to have authentic career influencing experiences.

14. Can or should the internship system be a mechanism for attracting doctors into specialties/locations of workforce need?

The intern year currently provides opportunities to expose doctors to a wide variety of specialist training pathways and workforce locations. However, the focus on training and patient safety should not compromised to meet workforce needs.

This requires the resourcing of supervision matched to the level of the competence of the intern.

In general, life decisions such as family, partner careers, children's educational needs and other personal factors have a large influence on career choices including location of the doctor.

Attracting doctors into specialties/locations is not about bonding doctors to locations but bonding doctors to their communities and career choices.

The other factor, is that being too prescriptive and restrictive on practice locations and speciality training choices may result in the best and brightest of students not undertaking medicine as a career choice.

15. **From a careers point of view what might be the risks and benefits of early streaming?**

The benefits include:

- Potentially more efficient matching of training resources to training outcomes
- Earlier acquisition of quality competency performance
- Fast-tracking career choices
    - This may be more important now as medical courses become postgraduate courses requiring a longer total period of time for people to complete their specialist training
    - In addition, this older age group entering medical training may exhibit more mature career choices than commenting medical training at a younger age and may be prepared to make careers decisions at earlier stage

The risks include:

- Making premature career choice decisions, although the evidence does not support this
- Narrowing medical career choices
    - Not all medical graduates choose a vocational training speciality and may move into research, industry, academia and other areas.
    - There will be more medical graduates than vocational training speciality places and so there needs to be registration pathways to support these medical graduates.

The better approach is one of flexibility allowing streaming to take place onwards from PGY2 second semester. The readiness of the individual being the critical factor.

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. What models might be viable to expand intern positions beyond the largely public health system model we have today?

The discontinued prevocational general practice placement program demonstrated/provided a model for safe and effective prevocational doctor year training in the community for both private and public community settings.

This standards for the prevocational general practice placement program ensured that prevocational doctors were effectively supervised and resourced in quality training positions, providing direct patient contact and an improved understanding of primary medicine.

This model could be extended to other speciality vocational training settings with each speciality providing a set of standards specific for community settings for each particular speciality. The standards need to differentiate between general foundation experiences and vocational training experiences for the particular setting, or may be flexible enough to support both possibilities in the one training post.

For example, a training position in a speciality area can support the development of generalist competencies, but if the position could provide an opportunity for providing relevant specialist experiences, then there may be the opportunity for such a position to support fast-tracking interns.

17. How could/should internships in the private and community sectors be funded and supported?

See the answer to question 16. The prevocational general practice training program provided funding models and developed standards for supporting these training positions.

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?

No. See answer to question 14. As medical courses become longer, further restrictions on workforce location will deter the best and brightest of students from taking up a career in medicine.

19. What options could be considered to fund training opportunities for medical graduates?

All funding opportunities need to recognise that medical graduates already provide health services to meet public health needs in addition to receiving training. This means that training should not be used as a source of free service provisions for the health system.

Other Comments

A revision of the intern training – especially in the second year of training (post-intern foundation year) could result in faster career progression, inter training systems need to recognise that many medical graduates will not enter immediately or at all, into the current vocational training pathways and so ultimately, any models of intern training will need to accommodate both these career pathways i.e. the fast-track and the nonvocational doctors.

Please email this submission to **medicalinternreview@coaghealthcouncil.gov.au**

Written submissions are due no later than **Friday 10 April 2015.**