

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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Written Submission Template**

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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?

“It is important to distinguish that there are certainly a number of core skills that we would expect an intern to learn and be competent at by the end of their internship. I would suggest that internships tend to be very unique experiences for most. I know it’s a cliché phrase, but the term apprenticeship-model keeps coming back to me. I would hate to see that lost.”

Doctor in training, Queensland

“I have not met anyone who genuinely believes that wholesale change is warranted or desirable. It’s interesting to me that those most passionate about the existing model of hospital-based internships and subsequent prevocational training years are often GP Registrars who report getting a lot of value from those years. I am quite concerned about the potential for quite harmful changes to be introduced without proper piloting and the impact this could have on trainees and ultimately patients. Internship contains very complex interactions of service delivery and learning (much of it informal and experiential) that drastic change without very careful planning could have all kinds of unintended negative consequences.”

Doctor in training, South Australia

The AMA supports the continuation of the intern year in its current form. The current model of internship is valued as a well-rounded, generalist, supervised and protected introduction to medicine which enables junior doctors to develop their medical skills and professionalism without having to focus on the demands of independent practice. It also enables junior doctors to learn about how the health system functions and how to navigate the public health system while being supervised and supported.

The well-rounded generalist orientation provided by the intern year enables junior doctors to develop, through practical training and experience, the professional knowledge and skills which will underpin their medical career and prepare them for the specialist vocational training offered by medical colleges.

Our doctor in training members have expressed unanimous support for the current model of internship and we feel strongly that this should be respected.

The AMA acknowledges that there are jurisdictional differences in intern training frameworks across the country. In this regard it is important to acknowledge the significant work already undertaken over the past two years by the Australian Medical Council (AMC) and Medical Board of Australia, with input from organisations such as the AMA, to implement a national framework for intern training that is robust and fit-for-purpose. This should not be overlooked and should be used to inform this review.

Importantly, the national framework developed by the AMC brings greater consistency to the intern training experience across all states and territories, facilitates vertical integration between basic, prevocational and specialist medical education, and enhances the quality of intern training by providing standardised assessment and progression processes. This framework maintains

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the traditional elements of internship, such as work -based training and core rotations, while also allowing for flexibility, innovation and contextualisation of training.

Rather than asking what needs to change, we would suggest the question should be why it should change. The current model of medical education and training in Australia produces doctors who are renowned worldwide for their high standards in clinical skills and professionalism.

Particular strengths of the current model of internship include an experiential model of training that enables graduates to consolidate and apply clinical knowledge while taking increasing responsibility for safe, high-quality patient care. Current training also allows for the development of diagnostic skills, communications skills, therapeutic and procedural skills.

The current model also supports a focus on generalism and generalist training in line with workforce and community need. This lends itself to producing prevocational doctors with broad-based medical skills that will hold them in good stead as they pursue different vocational pathways. Comparison with various international models, while informative, is limited as different health systems and governance models of training necessarily influence training design.

The possibility that provisional registration could be replaced by an alternative pathway other than internship to general registration for Australian graduates has also been discussed. This is very concerning as it could potentially create different tiers of trainees and a variety of alternative pathways to general registration that are not subject accreditation. The AMA supports one pathway for attaining general registration (e.g. internship) with careful accreditation and monitoring by the post graduate medical councils or equivalents.

Finally, it is important to note that the internship year is only one year of a lifelong journey of learning for medical practitioners. This begins in medical school and continues on through internship, residency, and specialist training (for those who choose to do so) and on to continuous professional development as a fellow. Medical practitioners are the product of this continuum of training, and an integrated and flexible model is paramount.

Further work to explore the validity of any changes to the current training model should be evidence-based and could include assessing:

- Whether there are any components of intern training that could be better redistributed within the health system i.e. paperwork.
- The benefits, consequences and practical application of introducing intern rotations that last for a longer period.
- The practical application of two year contracts for PGY1 & 2 nationwide.¹
- The educational validity of community-based internships. Should community-based internships/rotations be considered, then a careful pilot should be conducted to ensure there are no negative impacts on the educational quality of internships.
- The feasibility of introducing a national training survey to measure the relevance and validity of the current model of internship (see below).

National Training Survey

While significant work is being done to forecast and measure the quantity of undergraduate and postgraduate training places necessary, it has been more difficult to collect information on the quality of that experience across the continuum of medical training at a national level. An annual national training survey (NTS) of junior doctors is one mechanism that could be used to measure the quality of medical training in Australia, noting that each year the General Medical Council (GMC) conducts a NTS of doctors in the UK who are trainers or trainees to monitor the quality of medical education and training. In the UK, completing the NTS is a prerequisite for medical registration and is an important part of the evidence base and quality framework that the

¹ NSW offers two year contracts for PGY 1 & 2. While not a two year internship, NSW DiTs believe it acknowledges the continuum of training, lets junior medical officers build stronger networks within the hospital and offers a spread of terms/rotations of their choice across the two years.

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GMC uses to monitor standards in medical education, support inspections and provide feedback to those responsible for education delivery. The range of trainee surveys undertaken in Australia provides a bank of potential survey questions and design from which to construct a NTS. A single national survey also has the potential to replace the fragmented surveys that currently exist and provide the AMC with more timely and comprehensive data that can provide feedback as well as better inform AMC accreditation processes.

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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?

The internship is a foundation year of work-based learning that culminates in general registration to practise medicine. It is a key part of the transition period between medical student education and career development in a chosen specialty. The well-rounded generalist orientation provided by the intern year enables junior doctors to develop, through practical training and experience, the professional knowledge and skills which will underpin their medical career and ready them for the specialist vocational training offered by medical colleges. The AMA sees no valid reason for this to change.

While pre-internships, a two-year internship, early streaming and other alternatives to the current model of intern training will be explored as part of this review, the AMA supports maintaining the current model of an internship period of 47 weeks equivalent full time experience (excluding annual leave provisions) in supervised clinical practice prior to gaining 'general' registration. This should be in line with the requirements of the *Registration Standard - Granting registration as a medical practitioner on completion of intern training* and accompanying Australian Medical Council (AMC) National Internship Framework accreditation standards and guidelines for intern training.

The AMA also supports the continuation of compulsory core terms in emergency medicine, surgery and medicine of at least eight weeks duration in the intern year, with the remaining time comprised of other accredited terms. Training spent in these disciplines provides junior doctors with a well-rounded, generalist orientation to medicine, as well as exposure to a sufficient breadth of clinical experiences to enable them to develop and refine their medical skills and make informed decisions about future career pathways.

While much has been said about the effectiveness or otherwise of core terms in equipping junior doctors for current practice, well organised and properly supervised core terms that meet the AMC intern guidelines for terms and intern outcomes statements remain an effective way to provide the essential experiences in the emergency medical care, surgery and medicine that are required in the intern year, and to prepare junior doctors for emerging models of clinical practice.

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Reports suggest it is becoming increasingly difficult to provide every intern with a traditional general medical and/or surgical term, and that sub-specialty terms are commonly being used to provide this core medical/surgical term experience. This is appropriate in so much as they are able to provide exposure to the generalist skills that an intern needs to acquire, for example seeing and managing acute admissions in sub-specialty medical terms and pre-op, intra-operative and post-operative management in sub-specialty surgical terms.

Variation in clinical exposure during the internship year is to be expected and is not necessarily detrimental so long as each term is accredited and meets the AMC intern guidelines for terms and intern outcomes statements. Under this framework, skill acquisition during the intern year is supported by a national process for health services to certify interns' completion of the requirements of the internship, as well as assessment of interns' performance during the internship and remediation processes.

In addition, the Australian Curriculum Framework for Junior Doctors (ACF) has an important role to play in providing an academic foundation in the intern year and should be used to implement effective learning systems for junior doctors.

The AMA continues to support chronological block learning for core terms. Block learning provides interns with the ability to follow a patient through his/her entire journey, and provides for consistent supervision, assessment and constructive feedback. Exceptions to this principle should only occur if there is sound educational justification.

With regard to the method of assessment for the internship year, the AMA supports end-of-term assessments consistent with the AMC National Internship Framework. The AMA does not support formal centralised or standardised examinations for prevocational trainees.

The AMA acknowledges the New Zealand model of intern training which is competency based. While the flexibility associated with this model of training may be attractive, the AMA's position is that competency-based assessment should complement, but not replace, the current apprenticeship model of time-based internship training.

Competency-based training can be an effective component of medical education and training programs provided that safeguards are in place to ensure the high standard of medical education and training is maintained, and that trainees get access to an adequate depth and breadth of clinical experience. In this regard, the risks associated with competency-based training and time-based variable pathways must be acknowledged including being able to effectively assess the integration of knowledge and application of skills across a broad spectrum of scenarios, and the potential for time-based variable pathways to create a two-tiered system. The AMA considers that time and experience is a necessary part of training, and that specific competency in a procedure is not in itself sufficient evidence of competence to practice. Medical training to date has included the completion of a minimum number and type of clinical placements and rotations and the AMA supports the continuation of this model.

The AMA recognises the value of prevocational exposure to general practice and interns should have the opportunity to undertake a term in general practice if desired. General practice rotations give junior doctors a valuable insight into life as a GP and can help to inform their career choice. It can also help to build an understanding of how general practice works, informing future practice in other specialty areas. With a deeper appreciation of the role of GPs, other specialists can make better decisions about patient care and work more closely with their GP colleagues.

Such placements should be appropriately resourced to support participation and teaching in this area. However, while the notion of introducing a core term in general practice has merit, the AMA contends that it is not practical to introduce such a term in the current general practice environment, given the increase in the number of medical students and GP registrar training positions.

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The AMA was a strong supporter of the former Prevocational General Practice Placements program (PGPPP), which provided professional and well-supervised general practice placements for junior doctors as part of their training. Now that this program has been abolished, the AMA would like to see a replacement program established that is open to both interns (PGY1) and PGY2 doctors at the discretion of the practice.

While debate about the merits of early streaming forms part of this review, the AMA maintains that the development of "medical professionalism", which underpins the vocation of medicine, occurs best across a range of settings and medical disciplines. In this way the varied streams of medical knowledge and practice can be related and understood as part of an integrated whole. Graduates need time to be inducted into professional practice and need time to develop those attributes and skills that only come from time spent with direct patient care and through mentoring by senior clinicians. Early streaming cuts short this time and thus compromises the quality of medical training.

In this respect it is important to be clear by what is meant by the term early streaming versus elective choice by the clinician. The current model of prevocational training essentially allows prevocational doctors to 'self-stream' according to their field of interest. This is very different to any formalised process of early specialty streaming that would direct an intern into a particular speciality/career. The issues associated with early streaming are discussed in more detail in our response to Terms of Reference 3.

A generalist approach to intern training is in line with the need to develop a generalist medical workforce. For the purposes of this submission, the AMA defines the term generalist medical practitioner as referring to general practitioners (GPs), rural generalists and general specialists, such as general surgeons and physicians who retain a broad scope of practice.

The need for a generalist medical workforce continues to hold true even as medical education and training widens beyond public hospitals into private sector settings. Early streaming into specialty training works against that need.

The AMA also believes that a system of generalist prevocational training in the early postgraduate years also produces a more flexible and adaptable medical workforce than early streaming would allow. Interns and Resident Medical Officers (RMOs) can be assigned to and trained in smaller hospitals which do not provide a wide range of specialist services but may be well equipped to provide generalist medical training with strong mentoring in the intern and prevocational years. Early streaming into specialty training is likely to reduce the placement options of junior doctors, with particular effects on smaller rural communities which cannot support training placements in a wide range of medical specialties.

With respect to pre-internships as part of medical school training, the AMA supports 'pre-internship' placements to the extent that they ease the transition of students into their internship year. This is most often achieved through the student observing and performing appropriate parts of an intern's role under supervision, commonly by way of the medical student 'shadowing' an intern. Specific preparation for internship in the final year of medical school may help to relieve some of the anxiety that new graduates face on commencing work. It must be emphasised though, that it is not the role of undergraduate institutions to prepare medical students to be 'work ready' on the first day of their internship.

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?

The internship plays an important, although not exclusive role, in informing the career choices of junior doctors. Most junior doctors need to have a range of experiences and be exposed to different medical disciplines and settings before making a confident, informed decision about their specialty training. The intern year provides this exposure which not only assists junior doctors to make informed career choices, but also ensures they gain the necessary general experience that will provide a sound foundation for their specialist careers.

Data from the Medical Deans Australia and New Zealand Medical Schools Outcomes Database (MSOD) supports the value of the intern year in facilitating career decision-making by junior doctors. It has found that medical graduates are more certain about their career choices by the end of their intern year, with the percentage who were uncertain about their choice of speciality falling from 51% in their final year to 37% one year later in PGY1.

Scott and Joyce (2014)² acknowledge that 'medical career choices are a complex mix of individual aptitudes, preferences and characteristics; the structure of, and experiences during, undergraduate and postgraduate education; and the expected characteristics of different medical careers and jobs'. They suggest a number of new interventions may be appropriate to influence career decision-making by junior doctors including making available more national information about career options, vacancies and employment rates in specific specialties and specialty training programs, and altering the structure of medical training to promote flexibility and generalism.

In respect of the former, the AMA has developed a careers advisory service with the aim of providing realistic advice to doctor about career choices and planning (<https://ama.com.au/careers-advisory-service>) and is collaborating with the Confederation of Postgraduate Medical Education Councils (CPMEC) to make this information relevant to interns and prevocational doctors.

The AMA does not support the internship year being used as a mechanism for attracting doctors into specialties/locations of workforce need. While information on these specialties/locations should be provided and opportunities to experience practice in these specialties/locations promoted, the choice to pursue those must rest with the intern. The current model of internship provides prevocational doctors with the freedom of choice to explore specialties/locations of practice and to pursue term preferences outside of core term requirements. This allows them to consolidate career options and is the preferred model as opposed to early streaming or bonded placements.

² Scott A, Joyce CM. The future of medical careers. *Med J Aust* 2014; 201 (2): 82-83.

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Placements in areas of workforce need should be supported by practical and sensible policies and incentives to support such placements.

Early streaming and career choice

While early streaming has been discussed as a mechanism to decrease training time in response to medical workforce demand projections, this model is not supported by the AMA. It is important to be clear about what the current system provides in this regard i.e. accredited term preferences, and how this compares to early streaming.

Flexibility and generalism are important characteristics to preserve not only in the intern year but across the continuum of medical training. Broad clinical experience is important in ensuring doctors have the knowledge and skills to treat patients in a holistic manner. Graduates need time to gain clinical experience and develop professional skills through direct patient care and mentoring before moving into vocational training. Early streaming into specialty training following medical school would not only remove a vital phase in the medical training system that has earned Australia a worldwide reputation for excellence; it would also cut across the reality of the way in which doctors make their career decisions. Many doctors could find themselves locked into careers for which they are not really suited, with consequent implications for their participation in the medical workforce.

With Governments having approved very large increases in the number of medical students in Australia, the AMA has strongly pressed the need for greater investment in additional intern, prevocational and specialist training places to accommodate the extra medical graduates. The delay in tackling the downstream effects of these huge increases in medical school places remains a major concern. Finding enough well-designed and supervised places to accommodate all medical graduates in the early postgraduate period is a challenge enough. Increasing College capacity and accredited places for vocational training is another set of challenges again. Early streaming into specialty training would exacerbate these problems.

Under pressure to produce specialist doctors more quickly in a serious national shortage of doctors, several colleges have encouraged prevocational doctors to enter their vocational training programs in the second postgraduate year. The AMA acknowledges that this arrangement suits many individuals, particularly those emerging from the graduate-entry medical schools with considerable life experience and financial commitments. Many prevocational doctors may also feel pressured to enter vocational training early because of the impending wave of additional graduates from the large increase in medical graduates and the increasing costs associated with medical training.

However, while flexible and sensible responses to individual circumstances are to be encouraged, including College recognition of specific terms in the second postgraduate year, they should not undermine the current policy of having a period of generalist training and experience before entering specialty training.

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?

Training in expanded settings is now recognised as an important adjunct to the public teaching hospital model, benefiting both the trainee and the setting in which the training occurs. It enables clinical training relevant to future practice that may not otherwise be available in traditional settings. The AMA acknowledges the significant increase in the number of Government-funded prevocational training places in recent years, including growth in the private sector through the Commonwealth Medical Internship program which has contributed to increased intern training capacity.

Despite Government funding of training in expanded settings, there is a complex interplay of factors affecting the ability of facilities to provide ongoing training. Significant costs are incurred with medical training from the actual provision of training and from lost efficiencies relating to the training process. Current funding does not always cover the entire cost of the training position, and the fee-for-service funding model in private settings does not always easily accommodate the provision of medical education. These factors significantly impact on the willingness of institutions and private practitioners to provide training.

Equitable access to significant, dedicated and reliable funding for training positions in expanded settings is essential if positions are to be established with no financial detriment to the institution, supervisor and trainee. Funding must provide for full cost-recovery of providing high quality medical training, and must be indexed to guarantee the long-term sustainability of placements in expanded settings. The institution and practitioner must be compensated for the complete cost of participating in training.

The AMA supports the provision of intern training in general practice, private and community settings for prevocational terms, subject to them meeting relevant accreditation standards. These settings must be adequately supported and resourced to ensure that teaching remains a viable and sustainable proposition. In particular, alternative funding models and incentives to support general practice training are urgently required to ensure the pool of supervisors and training infrastructure meets demand for current and future training requirements.

Now funding for the Prevocational General Practice Placements Program (PGPPP) has been withdrawn, the opportunity exists to establish a new model of prevocational exposure to general practice. The AMA is currently developing its own model for prevocational exposure to general practice. Other options could include the establishment of models for community-based internships.

The viability of community-based internships has been the topic of discussion for the past two years. The AMA agrees in principle that this model has the potential to offer general practice and community health exposure to interns that could enhance professional and personal growth, and better integrate training requirements with the needs of the community.

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However, any future models of community-based intern training must meet the requirements of the *Registration Standard - Granting registration as a medical practitioner on completion of intern training* and accompanying AMC National Internship Framework accreditation standards and guidelines for intern training. The curricula should be designed to achieve the AMC global outcomes statements for intern training and the competencies outlined in the Australian Curriculum framework for Junior Doctors. Positions must be adequately resourced and supported, meet accreditation standards, and afford the doctor in training the same qualification as a public teaching hospital counterpart.

Participation in such a model should be 'opt in' to alleviate any reservations expressed by interns about the operation and/or equivalence of a community-based internship. A voluntary system would attract those already interested in a career in general practice and draw straight from the medical student population, rather than conscripting otherwise ambivalent interns into community-based settings.

If any new model were to be considered, the AMA reiterates the importance of the immediate supervisor being medically trained. The AMA's position is that interns should not be placed in a position where they are not adequately supported by senior medical staff and registrars. While non-medical professionals may be involved in the immediate supervision of some teaching and training activities within their scope of professional and clinical practice, they should not assume the role of term supervisor. Consistent with the relevant AMC documents, the overall term supervisor should be "a consultant or senior medical practitioner with experience in the management of patients in the relevant discipline".

The cost of an internship has also been the subject of debate. It should be acknowledged that the \$300 million 'cost' to fund intern positions reported in the consultation paper is not an entirely fair assessment, in that interns also provide a service as part of their training. Unbundling teaching and training from service delivery is not an easy task as shown by the work that the Independent Hospital Pricing Authority is undertaking to cost teaching and training using an activity-based funding methodology. It would be useful to see how this work intersects with the work of the Independent Hospital Pricing Authority to determine such funding models.

The AMA does not support linking availability of a paid intern year to a subsequent year of service in an area of workforce need. Mandatory return-of-service obligations are inappropriate for prevocational doctors, as they are not likely to lead to long-term recruitment of doctors to areas of workforce shortage and will stigmatise regional and rural practice. Interns should be recognised as valuable member of the health care team and should be paid as such with no conditions attached.

Rural terms fill both an important workforce and, service and educational need. Provided it is consistent with the development of appropriate clinical skills, the AMA supports the inclusion a regional/rural medical service component in postgraduate medical training programs, with junior doctors having the ability to pursue more advanced training in regional/rural medicine through their relevant Medical College.

Trainees should be encouraged to undertake rotations to regional/rural areas as part of their training program. Provided it meets the requirements of the training curriculum, trainees may elect to serve longer periods in regional/rural areas. The latter option should be available on a voluntary basis and trainees should not be compelled to serve extended periods in regional/rural areas by using de-facto workforce measures such as rural pathways.

Historically, there has been a gap in the educational infrastructure and oversight of prevocational doctors in rural areas and this has implications for patient safety and for the educational validity of placements. Clinical supervision gaps at a local level could be supplemented by supervision from medical practitioners at tertiary centres, using facilities now in place for telehealth, to create a supervision team.

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Examples of excellent practice that have been successful in expanding opportunities for junior doctor teaching, supervision and learning in rural and remote areas, and in locations that have had difficulty in providing sufficient educational oversight, should be identified and promoted.

Other mechanisms include specific preparation and training prior to the placement, briefing on the likely clinical problems and situations trainees will encounter, use of telehealth to communicate with senior doctors and other members of the supervising team, regular debriefing and mentoring.

Systems should also be in place to incentivise and support training in regional and rural centres. This includes policies to ensure trainees are not disadvantaged by undertaking regional/rural training such as enabling portability of entitlements, and providing housing and financial assistance to undertake rotations that require a move away from the usual place of residence. Coordinated recruitment processes for positions within expanded settings may facilitate trainee-movement more easily across settings. Establishing partnerships between new settings and traditional public teaching hospitals, universities and rural clinical schools will also help to maintain access to teaching facilities.

The AMA's policy on regional training networks (RTNs) leverages off already established relationships, institutions, infrastructure and experience to implement vertically integrated networks of health services and training hubs to provide prevocational and vocational training in regional areas. RTNs could support intern training in regional areas as well as provide a platform to encourage junior doctors to continue to practise in these areas as they establish professional and personal relationships and networks.

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Other Comments

A number of AMA Position Statements are also relevant to this topic including:

- Regional Training Networks - 2014 <https://ama.com.au/position-statement/regional-training-networks-2014>
- Fostering generalism in the medical workforce - 2012 <https://ama.com.au/position-statement/fostering-generalism-medical-workforce-2012>
- Medical Training in Expanded Settings – 2012 <https://ama.com.au/position-statement/medical-training-expanded-settings-2012>
- Regional and Rural Workforce Initiatives - 2012 <https://ama.com.au/position-statement/regional-and-rural-workforce-initiatives-2012>
- Supervision and assessment of hospital based postgraduate medical trainees – 2012 <https://ama.com.au/position-statement/supervision-and-assessment-hospital-based-postgraduate-medical-trainees-2012>
- Prevocational Medical Education and Training – 2011 <https://ama.com.au/position-statement/prevocational-medical-education-and-training-2011>
- The Role of Simulated Learning Environments in Postgraduate Medical Education and Training – 2011 <https://ama.com.au/position-statement/role-simulated-learning-environments-postgraduate-medical-education-and-training>
- Competency-based training in medical education – 2010 <https://ama.com.au/position-statement/competency-based-training-medical-education-2010>
- Core Terms in Internship – 2007 <https://ama.com.au/position-statement/core-terms-internship-2007>
- Pre-Internships In Medical School – 2007 <https://ama.com.au/position-statement/pre-internships-medical-school-2007>
- Early Streaming into Specialty Training – 2006 <https://ama.com.au/position-statement/early-streaming-specialty-training-2006>

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

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