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Dear Professor Wilson and Dr Feyer

MEDICAL INTERN REVEIW OPTIONS PAPER: AMA COMMENTS

Thank you for inviting the Australian Medical Association to comment on the options paper on medical internship in Australia paper prepared by the Medical Intern Review. Our response has been informed by the AMA Council of Doctors in Training (AMACDT). The AMACDT is made up of doctor in training representatives from each state and territory and is a conduit to the views of junior doctors across Australia. Our doctor in training members have been vocal in letting us know their opinions about the future of intern training in Australia, what aspects of the current model work and which aspects need to be retained and/or refined. These views are extremely valuable in describing the reality of training to complement the viewpoint of administrators and senior clinicians. We encourage you to embrace these views as you finalise your report.

We appreciate the opportunity to see the Review team's thoughts, and have the following comments to make, including responses to the specific questions in the options paper.

Are the issues, principles and constraints outlined here correct? Are any missing?

The AMA strongly supports maintaining quality, general medical training in the early prevocational years. 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.

It is vital that the positives in the current model of internship are not compromised for cost-savings or political expediency.

It is hard for us to agree that the current internship model is flawed when there is so much variety and flexibility across Australia, and when the calibre of doctors in training emerging are world-class and are regarded as such. That is not to say there is no room for improvement, but we do not believe this has to take the shape of frame-breaking change, and any change should be informed by a strong evidence base.

We do not believe there is enough evidence to show that the current model of internship in Australia is 'broken'. The Review clearly demonstrates there is a lack of data surrounding the quality and effectiveness of the intern year in preparing junior doctors for independent practice. Accordingly, an essential recommendation to come out of the review must be to establish systems to provide better information on the quality of medical intern training, the transition from medical school to intern training, and subsequently to PGY2 and beyond.

There is a critical need for a National Training Survey

The AMA strongly advocates for the implementation of a national training survey similar to the survey that the General Medical Council (GMC) operates in the United Kingdom. The UK-based survey attracts a 55,000 response from doctors in trainings a year and addresses medical workforce, medical training and employment concerns. It has been instrumental in providing data to training providers about what is working, what is not, and facilitates local system improvement by feeding back this data to training providers, including in relation to the 'work readiness' of graduates . This in turn contributes to improvements in training programs, patient safety and quality of care. We believe a national training survey must be part of a suite of strategies for ensuring intern training remains of a high quality and is fit-for-purpose.

The role of the AMC Intern Training Framework and ACFJD must be acknowledged

We also believe that the contribution of the Australian Medical Council (AMC) Intern Training Framework (ITF) and Australian Curriculum Framework for Junior Doctors (ACFJD) towards providing a framework for intern training needs to be acknowledged further. Together, these documents provide a clear framework for the required outcomes and competencies to be mastered by the end of the internship.

The ACFJD 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 ACFJD is applicable to prevocational doctors in PGY1, PGY2 and while we think it is currently underutilised and could add more value to prevocational training if implemented properly, this should not be misinterpreted as support for a mandatory two-year approach.

The AMC ITF took effect in 2014 and incorporates national standards, guidelines and resources to support the registration standard including intern outcome statements, assessment guidelines and a nationally available assessment form. In this regard it is important that any recommendations that arise from this review take into account the significant work already undertaken over the past two years by the 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.

Together with the ACFJD, these two documents provide a national framework for intern training, facilitate vertical integration between undergraduate, prevocational and vocational training, and enhances the quality of intern training by providing standardised assessment and progression processes. This framework combines the traditional elements of internship such as work-based training and core rotations with flexibility, innovation and contextualisation of training.

Would the necessary changes we propose deliver benefits in the system?

The AMA supports incremental, evidence-based change to the current model of internship focusing on improving supervision, assessment processes and expanding prevocational experience in non-traditional settings such as the community and private settings.
It appears that many of the issues raised as problems in the review, and therefore necessary of change of medical internship, seem to be problems with term accreditation rather than the inherent structure of internship. In respect of reduced clinical exposure for example, a Neurology term that is accredited as a core medical term is clearly not an appropriate medical experience if the team consists of a registrar and an intern, and sees between 0-4 patients at a time. To us, this suggests that processes to accredit terms should be more robust and that the bodies responsible for accrediting terms should be held more accountable.

The AMA believes that the review has downplayed the difficulty in creating high-quality rotations in expanded settings. There also appears to be a bias for the notion of a competency-based approach mapped against a curriculum. We do not think this is feasible in the current resource environment and ignores the value of experiential learning. Some doctors in training have said that they learnt more in a few weeks of supervised nights / cover shifts than they did in their final year of medical school, complete as it may have been with checklists of competencies they are expected to obtain. This is not to say that the assessment and teaching in internship could not be improved, but this in itself does not warrant a major structural change to internship itself.

Likewise we think the Review has also miscalculated the likely advantages to flow from reducing the number of rotations from five to four. The amount of time spent on orientation and assessment during a current intern term is minimal for the supervising consultant(s). Consequently decreasing the number of rotations from five to four is likely to have little impact on the amount of supervision and assessment an individual intern receives.

Where should we anchor rigidity in the system, versus allowing flexibility?

Rigidity

The AMA believes the following elements of the intern year should not be fundamentally changed:

- Graduates of AMC-accredited medical schools must continue to gain 'provisional' registration upon graduation and be required to complete an accredited 47-week equivalent internship.
- An accredited internship must continue to be comprised of mandatory accredited terms in medicine, surgery and emergency medical care in an acute care setting. Other non-mandatory terms must also be accredited. There is scope for flexibility on categories of mandatory terms, as detailed below.
- Terms must meet the requirements of the AMC with respect to what constitutes a medical, surgical or emergency medical care term. Using sub-specialty terms inappropriately as core medical/surgical terms puts at risk the generalist experience.
- Sufficient options should be available to trainees to allow a vocational emphasis in their training to occur. The opportunity to undertake several related rotations to explore a particular discipline as part of an overall career development plan is appropriate.
- 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.

- Competency-based assessments should complement, but not replace, the apprenticeship model of experiential, time-based internship training. It would be inappropriate for a system of progression through training to be based on skill acquisition rather than time served as this would very much undermine the experiential aspects of learning.
- Assessment during internship should be limited to end-of-term assessments consistent with the AMC National Internship Framework.
- A national exit examination is not necessary in the Australian context, and would unnecessarily homogenise the Australian undergraduate medical education system.

Flexibility

We do, however, think there is room for innovation in the following areas:

- Research into how best to measure and monitor the quality of medical graduates and medical school training programs, and the extent to which they prepare graduates for the intern year.
- General practice and expanded private and community settings for prevocational terms should continue to be actively pursued, subject to meeting relevant accreditation standards, but not at the expense of mandatory hospital rotations for core terms.
- The optimum length of terms in the intern year should be explored.1
- The options paper explores the concept of acute, sub-acute and community care as possible categories for mandatory terms. We recommend that further research and engagement with stakeholders be undertaken to determine how appropriate such a reconfiguration of mandatory terms would be.

Which of the options A-D would have most benefits?

The AMA is of the view that the options for change would be better presented as a spectrum or continuum, rather than an either/or option to take into account that Australia is a heterogeneous community and that no single solution will fit each area perfectly. Further, there is currently significant variability amongst internships across various health services in various states.

The "four options" model restricts change unnecessarily, as it does not allow these various sites to account for their respective variations. Some high performing sites will require very little change, whereas sites in difficulty may require significant change. We believe that by presenting avenues for change in a spectrum, rather than as dichotomous options, sites retain the necessary flexibility to correctly improve internship across the country.

[1] A recent survey of close to 500 Western Australian doctors in training found that 70% of surveyed doctors preferred five terms a year during their pre-vocational stage. 20% supported four terms a year, 7% supported six terms a year, and 3% supported three terms a year and none supported two terms a year. The reasons provided for these preferences centred on adequate broad exposure to multiple specialties over pre-vocational years. Longer terms were seen as an unnecessary extension of training time for the skill levels expected of a pre-vocational trainee, as detailed in the Australian Curriculum Framework for Junior Doctors. Longer terms were considered positively when provided in the context of a thematic year. For example, residents were satisfied with a shift to four terms a year if the year was structured as a "critical care" year, with dedicated exposure to specialties and educational opportunities related to the broader theme of critical care.

Option A aligns with the AMA's vision of quality, generalist medical training with improvements to supervision, assessment and education. The increase in term lengths discussed in Option **B** may be reasonable but require a greater evidence base before being considered as feasible for implementation e.g. changes to number of terms. The AMA wholly supports appropriate, high-quality community placements to complement the current internship model. **Option A** mirrors the current model which we believe remains fit-for-purpose, and provides room for evidence based incremental change to improve areas identified as not fit-for-purpose.

As stated in our previous submission to the Review, the AMA believes 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 AMA believes there is no evidence to support radical changes to the structure of the internship along the lines suggested in **Options C and D**. These options are unrealistic, would require a significant investment of resources, including cost and additional supervisor input, and may result in unintended negative consequences. In any case, it is unlikely that cash-strapped jurisdictions would be in any position to fund them.

While a two-year 'UK type Foundation' model at first glance looks attractive, we have no evidence that it would provide any improvement to the current model. We also note that the Foundation model was introduced as part of broad reforms to medical training – something which is outside the remit of this review process. Allowing core terms to be spaced over a larger time frame may disadvantage trainees hoping to enter vocational training in their second postgraduate year (possible in both Psychiatry and Physician training) and potentially delay the progression of others requiring mandatory specialty terms. In addition to lengthening the training pathway for these trainees, the model will unintentionally increase the number of trainees in the prevocational space.

The idea of drawing back internship-like duties into the final year of medical school is already done to varying degrees by existing medical schools with great success e.g. University of NSW, Monash University, and University of Adelaide. While pre-internship rotations are vital for the medical learning continuum, university-based learning is very different from the learning an intern gains in a workplace setting when they have the responsibility to make decisions about care under appropriate supervision.

The role of a university is to graduate their students. A university-based internship has no guarantee of the supervision or education that leads to safe medical practice. There is also the danger of further increasing final year medical student responsibility with respect to

medico-legal and industrial issues. There are legal issues for supervising interns, plus their supervisory burden limits them from undertaking higher-level tasks and thus learning more. Rather than reinvent the internship, we need to draw on what is already done well and make this the national standard. There is no evidence that the internship is 'broken' but there is always room for improvement and we should use this as an opportunity to re-define the national standard.

Finally and as already discussed, we think the potential changes presented in the paper would be better presented along a continuum rather than as four distinct options.

Are there any other areas of research or pilot projects that we should consider?

National Training Survey (NTS)

A working group should be established to explore the feasibility and value of implementing a NTS and to recommend next steps in the development and implementation of a NTS. This should include:

- Identifying and consulting stakeholders of the prevocational and postgraduate medical training processes on the aims and value of a national training survey and the plans for management of a survey.
- Identifying risks and policy issues associated with the implementation of a NTS.
- Proposing a governance structure to support the development, implementation and review of a NTS.
- Developing a strategy to implement a NTS, including dates for a pilot NTS and its full introduction.
- Identifying what content and data elements should be included in a NTS.
- Identifying a consultation strategy for ongoing engagement with relevant stakeholders.
- Identifying long term streams of funding to support the administration of an annual NTS.
- Providing advice on high-level performance indicators to measure the quality of medical training.
- Deciding at a high level on access to and use of the data.
- Deciding at a high level how the value of national training survey would be measured.

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. transferring responsibility for paperwork and red tape to clerical staff.
- The benefits, consequences and practical application of introducing intern rotations that last for a longer period.
- The feasibility of alternate categories for mandatory terms (e.g. acute, sub-acute and community care) and how appropriate such a reconfiguration of mandatory terms would be.

- The risks and benefits of the practical application of two year contracts for PGY1 & 2 nationwide.2
- The educational validity of community based rotations. Should community based rotations be considered, then a careful pilot should be conducted to ensure there are no negative impacts on the educational quality of internships.
- The introduction of nationally coordinated prevocational employment processes via a centralised system of offer and acceptance.

We look forward to future updates on progress with the review.

Yours sincerely

Professor Brian Owler
Federal President

Dr Danika Thiemt
Chair, AMA Council of Doctors in Training

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[2] NSW offers two-year contracts for PGY 1 & 2. While not a two-year internship, NSW doctors in training believe it acknowledges the continuum of training, enables them to build stronger networks within the hospital and offers a spread of terms/rotations of their choice across the two years.