ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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Prof A Wilson and Dr A Freuyer
Independent Reviewers
Australian Health Ministers Advisory Council
PO Box 6500
CANBERRA, ACT, 2600

Via email: medicalinternreview@coaghealthcouncil.gov.au

Dear Prof Wilson and Dr Freyer

Review of Medical Intern Training Discussion Paper

Thank you for your letter to the President, Professor Michael Grigg, inviting feedback on the discussion paper: Review of Medical Intern Training, which was forwarded to the Education Board for consideration.

Please find attached the written submission prepared by the Dean of Education. Should you require any further information, please contact Associate Professor Stephen Tobin at the College on (03) 9276 7468 or via email stephen.tobin@surgeons.org.

Yours sincerely

Simon Williams

Simon Williams
Censor in Chief

CC: Prof Michael Grigg, RACS President
A/Prof David Hillis, RACS Chief Executive Officer

WRITTEN SUBMISSION
FOR THE REVIEW OF MEDICAL INTERN TRAINING

This written submission is informed by the comprehensive discussion paper provided and by attendance at consultation session on 3/03/15 (RACS Melbourne).

Royal Australasian College of Surgeons
Associate Professor Stephen Tobin, Dean of Education
(03) 9276 7468 or stephen.Tobin@surgeons.org

Terms of Reference 1: Purpose of internship and where the current model remains valid and fit for purpose

Question 1 The main purpose of internship is the commencement of professional work as a medical school graduate. This includes learning to be a team member and early development of the identity as a medical practitioner. The discussion paper is comprehensive in its comments about what can be achieved in the internship year.

Question 2 Internship in its current form is considered reasonably fit for purpose. The current core terms in surgery medicine and emergency medicine are supported. Depending on the jurisdiction division of the year into a total of four or five terms should also give an option (or two) of testing a specialty of interest as a future career.

Question 3 Whilst supplementary training can be provided in the internship year through local hospital initiatives and including simulation approaches, most of the training component of internship is based directly around the clinical work.

Question 4 Would support internship continuing largely as it is. Flexibility to test each areas of career is supported. Expansion into a second year is reasonably supported as well.

Terms of Reference 2: Effectiveness of the intern year in producing doctors with appropriate skills and competencies to meet national health care needs including generalist practice

Question 5 The intern year is considered effective in building and assessing skills required for future practice.

Question 6 With reduced working hours and the expansion of the number of medical graduates, there is much to recommend a second year of internship. This could mean that internship is formally two years or it could mean that the vast majority of hospitals or networks employ young graduates for two years allowing some flexibility in the second post-graduate year.

Question 7 The variation in clinical exposure of the current intern model is not considered to matter significantly. There are many generic aspects of being a junior doctor and knowledge, skills and attitude to be developed during the first 1-2 years of practice should be able to be gained across many fields of medicine. Perhaps an exception to this would be very specialised areas of medicine and surgery tertiary-quaternary hospital setting, where the medical complexity may be overwhelming.

Question 8 There is much to recommend interns having a mandatory rural term and having a mandatory general practice term – this would be more easily organised with a two-year program.

Question 9 See response to Question 7. Would support interns continuing to have surgical and medical emergency terms.

Question 10 The Australian model of medical education does not support the early streaming approach, most prominently developed in North America. It should also be noted that many of the North American programs are such that several (1-3) post residency Fellowship years are utilized by many of the graduates from those residency programs.

Question 11 Because of the generalist nature of internship training in concept, internship itself is not considered to necessarily prepare doctors well for newly emerging models of clinical practice nor for any specific vocational training program. The standards required for entry to vocational training programs are normally superior to those that one would expect from a graduate from a 1- or 2-year internship program.

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

Question 12 General registration for a graduate of an Australian medical school is seen to be the outcome of an intern year in terms of recognition by the medical regulatory authority (Medical Board of Australia). This enables the junior medical graduate to have access to any particular training program in Australia. This supports the career pathway that may be embarked upon in terms of regulation but is not considered to necessarily impact that choice. Career decisions are seemed to made related to emerging issues in a particular specialty and at times the relationship between where that specialty can be practised and the geographic location of the junior doctor's early resident years. The exception of general practice is noted compared most other medical specialties that are still based as vocational training programs in the major cities. It would be appropriate to consider more regional based training programs (e.g. general medicine, general surgery, anaesthesia, etc.) to support better choice for interns training in mainly regional/rural areas.

Questions 13 and 14 are considered together

We are not advocating any particular major change to the internship approach. The usefulness of a workforce bureau or similar to more precisely describe the needs within the medical workforce (or alternatively to describe the variation seen within the maldistribution of location of practice of Australian trained doctors) is recommended. An early attempt is being made at providing useful workforce data by HETI (NSW Department of Health).

Question 15 Given the relatively limited clinical experience of graduate of Australian medical schools, and given the usefulness of the current internship process, early streaming in Australia would be seen to provide people with a less rounded overall medical education and much more tendency to specialisation and subspecialisation. Early streaming would therefore be seen to be in marked contrast with the generalism agenda recently advanced.

Terms of Reference 4: Models to support expansion of internship training settings

Question 16 Models to expand internship positions could include a mandatory term in general practice. This however would need considerable support at the general practice level and need to be allowed for in terms of time, supervision and remuneration. It is considered that there are limited opportunities for intern positions in private hospitals and again the requirements for time, supervision and remuneration are noted.

Question 17 As acknowledged in the discussion paper there is considerable background support from the health system for each of the internships available in public hospital setting. Clearly the concept of internships in private hospitals or in general practice in community settings would need to be suitably funded as well. The author has seen an early proposal from a medical education provider relating to internships in private/community sectors and the costing of that model was towards $250K per year per position for both salary and support. Whilst that figure seems high it is not much higher than the (overall) figures provided in the discussion paper.

Question 18 It is not recommended that the paid internship year be linked with a mandatory year of service in an area of workforce need. There is little evidence that prescribed location has been of any long-term benefit in filling workforce needs in the more remote areas of Australia particularly.

Question 19 No other options for funding of training opportunities for medical graduates seem obvious at this stage.

In summary, the review of medical intern training committed by COAG is seemed to be a worthwhile endeavour to consider the current model and potential reforms for medical graduate transition into practice.

The absence of structure in post-graduate years to onwards is noted by our College. Whilst CPMEC discussed accreditation standards for training over the years PGY2 to PGY4 several years ago, that has not led to any meaningful framework for junior doctors in their prevocational years. Reduced working hours and lack of structure in these years are thought to be associated with a less organised and less easily measured progression of the early medical career. Selection into post-graduate medical training programs is a complex subject. RACS has developed its JDocs curriculum framework to hopefully provide significant structure for professional development in the early post-graduate years. We are optimistic that this will provide a useful resource for the prevocational doctors of Australia in the years to come.

If further information is required please contact the undersigned.

Stephen Tobin
Dean of Education