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Independent Reviewers
Review of Medical Intern Training

SOUTH AUSTRALIAN
MEDICAL EDUCATION & TRAINING
HEALTH ADVISORY COUNCIL

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The South Australian Medical Education and Training (SAMET) Doctors-in-Training (DiT) Committee was grateful for the opportunity to review and provide feedback on the options paper arising from the National Review of Medical Internship.

The DiT Committee exists under the auspices of the SAMET Health Advisory Council and one of its functions is to provide comment on matters relating to trainee medical officer education, training and welfare. The Committee is comprised of junior doctors in prevocational and vocational training and also medical students from across South Australia. The National Review of Medical Internship was felt to be highly relevant to this function of the Committee given its potentially major impacts on internship in Australia, which is a critical component of junior doctor training.

Members of the Committee held differing views on ideas raised in the options paper and these have been summarised below, grouped against the ideas themselves.

Impetus for change:

Some members agreed there was a case for change to the current internship model while others felt that no change was warranted.

Those who felt that no change was warranted believed that the impetus for change was assumed in the National Review of Medical Internship documentation rather than lucidly or successfully argued. These members also felt that the National Review of Medical Internship erroneously predicated many of its recommendations / options on assumptions made about the nature of medical training and work in the future with excessive confidence and without providing credible reasoning or evidence that these assumptions will eventuate in reality.

Increasing responsibility for final year medical students:

Overall, members of the Committee agreed with the notion of increasing responsibility for final year medical students. This was seen as a positive way to improve graduate readiness for internship. It was noted that many universities are already doing this; for example, one of our final year student members noted that she already sees surgical patients independently in pre-admissions clinic, with her supervising intern simply co-signing her work once it is done.

However, the Committee had a number of concerns about further increasing responsibility for final year medical students, as follows: (a) there may arise unacceptable medico-legal liability for interns, (b) the supervision burden on interns means that having medical students take on more responsibility may not actually meaningfully increase the time they can spend doing higher-level tasks and thus learning more, (c) there were some concerns that the final year medical students would not be 'owned' by either the relevant university or health service and that this may lead to unsatisfactory supervision and pastoral care environments, and finally (d) pressure for service delivery may produce scenarios in which final year medical students are utilised unfairly or inappropriately by either interns / more senior doctors or the hospital and, in the context of existing outside a regular industrial relationship with the health service, such final year medical students may have unacceptably limited avenues for recourse.

Increasing exposure to community-based medicine:

The Committee was split on the value of increasing exposure to community-based medicine. Some members supported the idea, especially if integrated into the second year of a two-year internship model. The relative lack of community-based practice in the current internship model was noted by the Committee. However, other members of the Committee opposed the concept altogether or suggested that it should only be voluntary for interested junior doctors.

Some of the concerns around community-based rotations included: (a) perception that there may be a lack of adequate supervision and teaching opportunities, (b) the value of having a 'home hospital' for peer support and pastoral care purposes, and (c) perceived higher pedagogical value of time working in a hospital.

It was noted that provisionally registered doctors are currently unable to request pathology or radiology or prescribe medications outside of a hospital, which significantly impinges on the responsibility and independence that such doctors can have in the community; this is likely to be a major detractor with respect to the educational value of community-based rotations, as it is the assumption of responsibility that is a key driver of learning for interns.

It was also noted that the Royal Australian College of General Practitioners currently requires trainees to have conducted at least two years in a hospital (internship and then one further year). It is assumed that the College sees significant educational value in this second year for trainees who will go on to spend all (or at least the vast majority) of their time in the community setting. Introducing community-based rotations into internship and / or a two year model should carefully consider this requirement of the College with respect to both its alignment with the hospital-based experience that the College believes its trainees require, plus its significance for any proposed soft or hard streaming in a two-year internship / prevocational training period.

Longer terms:

The Committee was broadly (but not ubiquitously) comfortable with the notion of changing internship to include four rather than five rotations. However, it was noted that the numerical reduction in exposure of interns to different specialties may impact negatively on career planning.

Furthermore, the Committee strongly disagreed with the assumption that decreasing the number of rotations would improve intern supervision or teaching. It was noted that current orientation and assessment of interns took very minimal time and a 20% reduction in these requirements would have absolutely no material impact on the time senior staff have available to supervise and / or teach junior doctors. This is abundantly clear from examining the situation for prevocational doctors who currently have four rotations in one year.

Some members of the Committee highlighted their concerns about the lack of supervision provided for interns on surgical rotations with respect to managing medical comorbidities. Any effort to address this lack of supervision was seen as positive, but again it was highlighted that merely extending rotation would not materially affect supervision provided.

Some members of the Committee highlighted their view that the three mandatory rotations of medicine, surgery and emergency medicine should be continued to ensure well-rounded exposure to the key areas of hospital-based medicine. If the mandatory rotations are continued then decreasing the overall number of rotations may confound rostering and service delivery requirements.

Two-year internships:

Members of the Committee held differing views on moving to two-year internships or requiring graduates to undertake two years of general prevocational training. Some

felt that this would improve overall education for graduates. Others felt that this would unnecessarily lengthen training time for a significant number of graduates.

It is noted that in South Australia there is a long history of successful streaming of interns directly into vocational training pathways such as physician and psychiatry training. We are not aware of any evidence that this leads to suboptimal pass rates or suboptimal practitioners at the end of vocational training. Therefore necessitating two year periods of prevocational training after graduation would lengthen total training time for many South Australia doctors.

It is suggested that prevocational training may count towards future vocational training via recognition of prior learning. However, some Colleges are moving away from this approach already and some members of the Committee believe that the assumptions of the National Review of Medical Internship regarding the ease and likelihood of recognition of prior learning are unrealistic.

Limitations:

Some members of the Committee highlighted what they felt to be limitations of the approach to the National Review of Medical Internship which may jeopardise the validity of its proposals. The first key concern was that some members felt that the review was flawed in that it did not consider, or did not appear to give sufficient weight to, the crisis in medical graduate numbers and capacity problems in the intern and prevocational training arenas. International students are already missing out on internships, compromising the sustainability of international student fees as a method to subsidise nationally underfunded medical education in Australia, and some members of the Committee have heard anecdotal reports of local junior doctors missing out on prevocational training jobs. Some members of the Committee felt that any proposals to change internship must address this growing crisis.

The second key concern was that the National Review of Medical Internship has been too narrow given its terms of reference restricted its assessment to internship alone. It was noted that internship is a key transitional year in a broader and more complex training pathway from undergraduate medical student through to fellowship. Some members of the Committee expressed their view that this entire pipeline is pressurised and needs review, and that changes to internship should be considered only in a broader context.

Other specific feedback

Individual members of the Committee raised other concerns on specific points in the options paper as listed below.

Mandatory time versus mandatory skills:

There is a proposal to focus more on the acquisition of core skills (as assessed via checklist) rather than on conducting a rotation of a set length, with the assumption that some core skills will necessarily be acquired during that rotation. Some members of the Committee remarked that greater oversight was required to ensure interns are indeed acquiring the core skills that they are expected to acquire, with support for more assessment / checklists during internship and one suggestion of a national intern exit examination.

Some members of the Committee, however, were concerned about the proposal to move to a 'competency-based' approach to internship where a candidate might progress to the next stage of training as soon as they were able to demonstrate they had achieved the relevant set of core skills. The underlying reasons were (a) checklists and certification of competence would be open to significant variation and thus validity and fairness would be very difficult to ensure, (b) there are many significant experiential aspects of medical training that cannot be compartmentalised as 'skills' or easily assessed as such, and trainees and patients may suffer from any diminution of these elements of training and (c) it would be logistically very challenging to implement in the current context of the structure of junior doctor employment.

Hospital-based internships leading to a preference for specialties:

One member of the Committee noted the statement in the options paper that hospital-based internships caused trainees to develop a preference for training in a hospital-based specialty. We are not convinced of the veracity of this statement and note that general practice training places are oversubscribed in South Australia.

Categorisation of general skills:

One member of the Committee noted the categorisation of generic skills into three different groups on page 16 of the file (transition to practice, clinical skills and experience and philosophy of care). The member felt this was an apt and useful categorisation of generic skills but recorded the view that the current model for internship does achieve adequate proficiency in all of these areas already.

Bonding:

We agree that bonding should not be a preferred method for addressing service delivery gaps.

Emergency medicine rotations:

One member noted the comments in the option paper regarding the difficult of sourcing sufficient numbers of emergency medicine rotations. However, the view was put that this difficulty is not a valid reason to scrap mandatory emergency medicine rotations altogether, which provide useful opportunities for the work-up of acute undifferentiated patients. It was seen as 'treating the symptom and not the disease'.

Service delivery:

We believe that most interns in South Australia provide a sufficient level of service to justify both their salaries and the training they receive while working.

We hope that this feedback can be of use to the National Review of Medical Internship and we would be very pleased to be involved in any further consultation, if required.

For and on behalf of the SAMET DiT Committee,

Yours sincerely,

Tom Crowhurst
Chair
SAMET Doctors in Training Committee