CPMEC
CONFEDERATION OF POSTGRADUATE MEDICAL EDUCATION COUNCILS

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Medical Council of New Zealand Education Committee
Canberra Region Medical Education Council

17th July 2015

Prof Andrew Wilson
Lead Reviewer
COAG Medical Intern Review
C/o NSW Ministry of Health
NORTH SYDNEY, NSW 2060

Dear Andrew,

RE: CPMEC RESPONSE – MEDICAL INTERN REVIEW OPTIONS PAPER –MAY 2015

Thank you for giving CPMEC an opportunity to provide written feedback on the Options Paper and for meeting with us for a second time on 15th June 2015.

Our response has been structured around the feedback questions outlined in the Options Paper and our discussions with you. We have focused on what we consider to be the more important issues and have tried to present a collective CPMEC perspective, noting that some of these views may not be supported by all our members because of jurisdictional priorities. Naturally, we would be happy to clarify any points raised in this document.

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

CPMEC notes the key consultation findings, which are generally in accord with our own assessment of the current state of prevocational training. We strongly support the broad agreement identified in the consultation findings on the value of a structured, supervised transition to the workplace as a critical first step in the postgraduate training continuum.

We support the review team's comments on the consultation findings for each of the terms of reference and the team's identification of the issues to be addressed under the two key areas for reform – achieving better quality training and aligning internship with societal needs through the right workforce mix and distribution. We also support the guiding principles that the team has suggested should underpin any changes to the intern year.

CPMEC agrees that there are a number of constraints and trade-offs applying to any changes to prevocational training, which have been identified in the Options Paper.

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We agree that it would be difficult to make meaningful changes to the intern year without taking into account aspects of university and vocational training. Graduates' choice of intern site and rotations is strongly influenced by (mostly accurate) perceptions about criteria for selection into training programs. As the gap between the number of graduates and the number of vocational training positions grows, there are increasing incentives to complete prevocational training in subspecialised inner metropolitan teaching hospitals. This is unlikely to change unless vocational training pathways are made available in outer metropolitan and regional centres.

We also agree that any proposed changes must be grounded in the changing context of health service delivery in Australia. We would suggest that the best way to understand the context of service delivery is to consider four main types of healthcare services: critical care; acute care; chronic and complex care; and primary and preventive care. Hospitals, where the overwhelming majority of interns spend most of their time, deliver critical and acute care, as well as a limited amount of subacute in some sites.

The structure of dedicated wards, units and outpatient clinics which underpinned hospital internship in the past has been transformed and many specialties have limited numbers of inpatients requiring acute or critical care. There is a much greater focus on throughput and early discharge, with the result that junior medical staff have fewer opportunities to assess patients and contribute to clinical planning, or to observe or contribute to longitudinal care. During most rotations there is a high turnover of consultant and sometimes registrar staff, which results in patchy supervision. Many interns are attached to specialized units with a limited case-mix range. One effect of these changes has been an undervaluing of the role of interns, and to some extent PGY2 trainees, by health services and some supervisors. In some cases this has contributed to reduced educational and supervisory support. As discussed in the Options Paper, interns and residents consistently report that their best experiences are in Emergency Departments, where they have more exposure to undifferentiated presentations, more opportunities to develop clinical reasoning skills and better supervision.

Primary and preventive care and most chronic and complex care is delivered in the community, covers the biopsychosocial spectrum of healthcare and provides much better exposure to longitudinal care. As noted in the Options Paper, it is not confined to general practice. Exposure to primary and preventative care, and to delivery of chronic and complex care across the course of disease is significantly absent from most intern and PGY2 programs. This is a fundamental weakness in Australian prevocational training, which reflects a lack of integration in the Australian healthcare system.

Funding, supervision, educational support and pastoral care of community based training posts are major constraints for any reforms of prevocational training designed to address this weakness, as was graphically illustrated by the impact of the recent decision to discontinue the Prevocational General Practice Placement Program, further limiting junior doctors' exposure to community based care. CPMEC believes that any meaningful reform will require a coordinated approach by Commonwealth and State and Territory governments.

Prevocational training is overseen by national bodies in the United Kingdom (the General Medical Council) and New Zealand (the Medical Council of New Zealand). Early postgraduate training is managed by university consortia in Canada and the US. We suggest that any meaningful change in Australia will be very difficult without some sort of national body responsible for prevocational training.

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

CPMEC agrees that any changes will almost certainly require more flexibility in the intern (and PGY2) year than is allowed under the current format. CPMEC supports changes to the current structure of the intern year but notes that under the National Registration and Accreditation Scheme, the composition of the intern year is the responsibility of the Medical Board of Australia. Any changes will need MBA approval.

CPMEC supports a flexible two year approach to prevocational training that does not increase the duration of medical training. We suggest that a more flexible approach could potentially provide better Emergency Department exposure and better exposure to community healthcare for more trainees.

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

CPMEC supports the recommendations on changes that should be made regardless of which option is recommended:

i. **Making training more holistic through experiences that span the domains of patient need, care contexts, settings and safety. (**See comments above)

ii. **Integrating education in models of care.**
Integration of education into models of care is the basis of the apprenticeship model of internship. This integration is under threat as a result of the changes to hospital models of care discussed above. CPMEC would be interested in contributing to pilot studies designed to improve integration.

iii. **Improving supervision**
Better supervision would significantly improve development of clinical skills and would also enhance patient safety. For many years CPMEC has advocated for the same level of supervisor training and support for interns and PGY2 doctors that is routinely provided to medical students, graduate nurses and vocational medical trainees. It is difficult to understand why there is such a gap in Australia in the regulation and training of those responsible for the supervision of the group of trainees with perhaps the highest learning requirements, the greatest need for pastoral care and the most potential to cause adverse events. Support for supervision of junior doctors in the UK and New Zealand is much more comprehensive and effective.

CPMEC and its member Postgraduate Medical Education Councils have undertaken a significant amount of work over the past decade to enhance the quality of prevocational supervision through national professional development programs for Directors of Clinical Training, registrars, junior consultants and other medical educators. Unfortunately these programs have limited funding and are only available to a small number of supervisors – in marked contrast to the availability of equivalent programs developed in the UK.

Support for supervisors of Australian medical students and vocational trainees is mandated and provided by medical schools and Colleges. Support for supervisors of UK Foundation programme trainees is mandated by the UK General Medical Council. Support for supervisors of New Zealand prevocational trainees is mandated by the Medical Council of New Zealand. North American residency programs provide extensive support for supervisors. A national approach to improving

supervision for Australian prevocational trainees is unlikely unless there is a national body responsible for prevocational training

iv. **Valuing after-hours work**

CPMEC has been a strong supporter of improved supervision and education after-hours. Member PMCs have contributed to the development of several innovative projects in a number of jurisdictions. We strongly support a national approach. Once again this is much more likely to be successful if there is a national body responsible for prevocational training.

v. **Improving assessment and more individual accountability for learning.**

CPMEC supports a more robust assessment program and investigation of educational tools like e-portfolios, professional development plans and Entrustable Professional Activities. However, any benefits will be very limited without a clear national statement of the educational goals of the intern (and PGY2) year.

CPMEC strongly agrees with the statement in the Options Paper that one of the weaknesses of the current internship is an assumption that skills and experience will be gained through completing time in mandatory terms, without these being specified or meaningfully assessed. This has become increasingly untenable with increased numbers of medical graduates and creation of large numbers of new intern positions in sites with limited experience of intern supervision and training.

The challenges of undertaking and delivering educational activity in a service environment are considerable with widespread education-service tensions. Clearly stated, agreed educational expectations are a powerful influence on health service culture and help to moderate the variability of intern learning experiences without preventing local approaches consistent with community needs.

The Australian Curriculum Framework for Junior Doctors (ACF) has served as the de facto educational template for the first two postgraduate years in the absence of a mandated curriculum. It was initially funded by Medical Training Review Panel (MTRP) project funding but since this funding has been discontinued its implementation and further development have been significantly restricted. The framework has been incorporated into the recently developed AMC intern outcome statements, it has been used as an end point by a number of Australian medical courses and has been viewed as a starting point for some Colleges. It was extensively adapted by the Medical Council of New Zealand in its recent reform of prevocational training. Despite limited resources, CPMEC has attempted to keep the ACF up to date through three yearly reviews.

A national curriculum framework and national assessment standards have been achieved for Australian medical students and vocational trainees through the Australian Medical Council and Colleges. A national curriculum framework and national assessment programs are mandated for UK Foundation programme trainees by the UK General Medical Council and for New Zealand prevocational trainees by the Medical Council of New Zealand. It is unlikely that a national curriculum and improved national assessment programs can be implemented in Australia without a well-resourced national body responsible for prevocational training.

CPMEC notes the lessons learned from the introduction of a complex and resource intensive assessment program for UK Foundation Programme. Any assessment process that is introduced in Australia should be commensurate with the resources available to support it. CPMEC suggests that prevocational assessment should recognize that interns have already completed stringent assessments and that it should be based on two key principles:

- achievement of appropriate performance benchmarks rather than seeking to spread candidates along a performance continuum;
- identifying the small number of trainees who fail to meet these performance benchmarks, with a view to providing a personalised remediation programs. Remediation programs will require resources if they are to be successful.

vi. **Integrating transitions from university and prevocational training and from prevocational training to vocational training**

CPMEC strongly supports better integration of transitions between university and prevocational training and between prevocational to vocational training. We suggest that any proposals requiring changes to the final year of Australian medical courses are carefully evaluated as there is considerable variation in the contents of final year programs between four, five and six year courses and MBBS and MD courses.

Once again significant improvement is unlikely unless there is a national body responsible for prevocational training.

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

CPMEC generally agrees with the review team's assessment of the risks and benefits of each option. We note that when the National Registration and Accreditation Scheme (NRAS) was introduced it took several years to transition from jurisdictional-based bodies to a national one while largely maintaining the status quo. Any changes proposed should be realistic and phased and will need to be supported by the Medical Board of Australia and the Australian Medical Council and critically, by all levels of government.

CPMEC supports the approach proposed in Option C. We think the level of change proposed is feasible, especially if preceded by pilots to evaluate the impact of the changes. We believe that any change to the intern year should also be designed to facilitate improvements to PGY2, particularly better educational support, and to allow for some early streaming for those PGY2 doctors who have made a career choice.

E. Are there other areas of research and pilot projects we should consider?

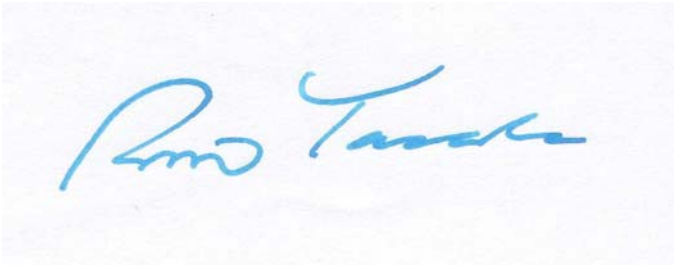
CPMEC strongly supports research and pilot projects to address evidence gaps and develop common tools. We note that there have been very many successful pilot projects over the last decade, particularly during the period that the Medical Training Review Panel supported national priority projects in prevocational medical education and training. With some notable exceptions (the Australian Curriculum Framework for Junior Doctors, the Professional Development for Registrars Program, the Prevocational Medical Accreditation Framework, Teaching on the Run) very few have been continued after project funding has been expended - it will be important to implement the findings of any research and pilot projects arising from this review. CPMEC encourages the review team to make some strong recommendations for systemic changes (and for the resources that will be necessary for them to endure), rather than just recommend research and pilot programs.

CPMEC believes that the most urgent need is to establish and implement a national curricular framework, most likely based on the Australian Curriculum Framework for Junior Doctors (ACF). The next three yearly review of the ACF (scheduled for this year) is an opportunity to address perceived gaps in prevocational experience and to develop learning resources to support the educational goals of prevocational training, including national dissemination of many existing high quality materials produced for local use. It is also an opportunity to develop a national consensus approach to post-PGY1 prevocational curricula by better integration with College curricula, particularly for generic components.

Thank you again for giving us the opportunity to provide feedback. We look forward to receiving updates on the progress of the review.

Should you have any queries about our submission, please contact our Chief Executive Officer, Dr Jag Singh, on 0423 064 346 or by email at jsingh@cpmec.org.au

Yours sincerely,



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