Governing the reform of the medical internship

Implementing the recommendations of the Review of Medical Intern Training will be challenging and will require reconsideration of medical training governance

In 2014, the Council of Australian Governments commissioned the independent Review of Medical Intern Training, which was led by Professor Andrew Wilson and Dr Anne-Marie Feyer. The purpose of the review was "to examine the current medical internship model and consider potential reforms to support medical graduate transition into practice and further training".[1] The review involved regular interaction with external stakeholders, including the invitation of submissions in response to an initial discussion paper and consultation regarding a later options paper.[2] The review's final report (the Report), released in October 2015, has been considered by the Australian Health Ministers' Advisory Council, which has made recommendations for a wide-ranging working group overseen by the Health Workforce Principal Committee to investigate the feasibility, prioritisation and sequencing of the Report's recommendations.

The rationale for the review was multifactorial and included:

- a lack of previous comprehensive national evaluations of medical internship;
- recognition of changing educational and health care delivery paradigms;
- continuing medical workforce maldistribution, despite a doubling of medical graduate numbers nationally over the past decade; and
- increasing medical education and workforce costs, even though hours worked per medical graduate are declining.[3]

The review noted the strengths of, and general support for, the current apprenticeship-based model of internship, but also noted limitations in its delivery, including dilution of clinical experience in the rapidly changing acute health care setting. This was a substantial review, and its recommendations (summarised in Box 1) will have significant implications for providers and participants in medical training.

The "purpose" of pre-vocational training

A fundamental problem with any review of internship is that internship does not occur in isolation. Instead, it is arguably the most significant transition period in the medical training continuum and is therefore often loosely described (as it is in the Report) as "a transition to practice" and "progression towards independent practice". This belies an alternative argument that the pre-vocational period may have specific educational entry and exit requirements that could more usefully describe its purpose. If this premise were adopted, the implementation of this review provides an opportunity to redefine the pre-vocational period and, in so doing, to reconsider an appropriate educational governance structure.

"a national integrated governance structure across all phases of medical training would allow for better pooling of limited resources"

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A fundamental minimum requirement of all clinicians is that they be safe practitioners. In particular, international and local literature notes that clinical risks arise from the training of health professionals (predominantly junior doctors);[4] that doctors in training may expose patients to harm because of lack of knowledge, experience and supervision;[5] and that junior doctors may be involved in adverse events and hence require adequate supervision.[6] The transition from medical graduate to practising clinician requires a generic understanding and performance of safe practice as a key objective. Workplace trust that a trainee can undertake appropriate tasks safely under supervision forms the basis of "work-readiness".

Conversely, exit from the pre-vocational period — the transition from pre-vocational to vocational doctor — requires that graduates have the general and specific prerequisite knowledge, skills and competencies to commence vocational training. Recently, some colleges have defined a vocationally aligned pre-vocational curriculum in an attempt to better prepare junior doctors for vocational training.[7] These are valuable initiatives but are not yet part of an integrated interdisciplinary curriculum strategy for junior doctor training.

Defining the entry and exit requirements of the pre-vocational period provides an opportunity to strengthen internship governance, which, while beyond the scope of the review, was considered to require additional resources and strong stakeholder partnerships and collaboration.

Governance of pre-vocational training

The current model of governance of pre-vocational training differs from the governance models of the other components of the training continuum (Box 2).

The Australian Medical Council (AMC) sets the overall standards required of the training organisations; however, the pre-vocational period does not have a training organisation equivalent to those of the other (entry to practice and vocational) periods of training. The AMC standards for medical schools have instead been adapted in the implementation of the National Intern Training Accreditation Framework[8] as standards for individual training providers (the health services). Despite high quality training programs in many individual health services, the lack of independent training organisation oversight of these in the pre-vocational period creates the potential for:

- conflicts of interest between the employer and training provider roles of a health service;
- poor understanding of aggregate pre-vocational trainee outcomes and exit rates; and

1 Recommendations of the Review of Medical Intern Training[1]

The reviewers recommended:

- That the internship be changed to:
  - provide clinical experience in the full patient journey;
  - require demonstration and assessment of specific capabilities;
  - ensure development of competence through being given responsibility under supervision; and
  - enable individual accountability for learning
- That the internship should have entry requirements that reflect agreed and defined expectations of work-readiness
- That internship move to an integrated, 2-year transition-to-practice model
- That a range of initiatives be undertaken to support the change process and further investigate aspects of the 2-year model
- That career planning across the medical education continuum be better aligned with societal health and medical workforce needs
- That expansion of training settings is further supported
- That recommended research and development activities occur to support the change process ◆

- lack of coordination with medical school and vocational training.

Further, the lack of previous large scale training reform within the current internship model may be considered a by-product of this devolved governance approach.

While the Report recommends that the AMC be the national auspicing body of internship, its role should be carefully considered. The AMC provides high level oversight of medical school and vocational college training programs, but it is not responsible for training delivery and ongoing evaluation at an operational level. While the AMC should appropriately also have high level oversight for the pre-vocational period, an entity to develop and implement pre-vocational educational governance may be best established through existing bodies such as Medical Deans Australia and New Zealand (MDANZ), the postgraduate medical councils and the Committee of Presidents of Medical Colleges.

Historically, oversight of the pre-vocational period has been the remit of jurisdictional departments of health and workforce planning bodies such as the Health Workforce Principal Committee, due in part to the medical workforce implications of medical graduate numbers. Nevertheless, the educational importance of the pre-vocational period in developing safe practice, clinical confidence and competence to support entry to vocational training, and in assisting in career development, is increasingly recognised. The findings of the review, despite an exhaustive academic and consultative process, are acknowledged to have been limited by a lack of large scale research and evidence regarding pre-vocational training. Given that intern terms have progressively been created over the past decade in disciplines such as psychiatry and extended general and community practice, the lack of evaluation of their collective contribution to learning and skill development in the intern year is a lost opportunity.

2 Current governance structure of medical training in Australia

	Entry to practice	Pre-vocational	Vocational
Accrediting body	Australian Medical Council	Australian Medical Council Medical Board of Australia*	Australian Medical Council
Training organisation	Medical school	Postgraduate medical council†	Vocational college‡
Training provider	Health service or participating clinical site	Health service or participating clinical site	Health service or participating clinical site

* The Medical Board of Australia accredits intern positions in all states and territories, as recommended by the jurisdictional postgraduate medical council (or equivalent). † Postgraduate medical councils (or equivalent) are accredited by the Australian Medical Council for their governance and accreditation functions but not for educational or broader training organisation functions. ‡ For general practice, vocational training is provided in health services and general practice clinics with support from regional training organisations that are contracted to the Australian Government to provide training to the standards of the vocational colleges. ◆

Governance of the medical training continuum

Internationally, there are many and varied models of governance of medical training, reflecting different structures and systems. In the United Kingdom, the General Medical Council considers advice regarding the continuum of medical training from its Education and Training Advisory Board.[9] The Royal College of Physicians and Surgeons of Canada provides oversight of 79 currently recognised disciplines of postgraduate training, as well as residency and professional development programs.[10] These international models comprise integrated training frameworks incorporated in organisations that also manage practitioner, workforce and health policy-related matters. Models such as the Canadian Royal College's CanMEDS medical education competency framework and the UK's Foundation Programme have had substantial success and influence on medical training internationally; the latter has had a significant influence on the Australian pre-vocational curriculum and the introduction of postgraduate performance assessment frameworks.

Currently, resources to support medical training in Australia across the continuum are dispersed via a wide range of stakeholders. Beyond a new model of governance for the pre-vocational period, developing a national integrated governance structure across all phases of medical training would allow for better pooling of limited resources and would support a nationally integrated and consistent approach to medical training and workforce planning. Such a model should provide medical educational leadership and bring together existing key stakeholders, such as MDANZ, postgraduate medical councils, colleges, the AMC and medical workforce agencies, that would report through to the Medical Board of Australia. Future evaluation of pre-vocational training, and indeed any implementation of the Report's recommendations, will need to be led by a national educational body with the appropriate expertise, resources and authority.

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