10 May 2012

Mr Warwick Hough
Senior Manager
General Practice, Legal Services and Workplace Policy
Australian Medical Association

Dear Mr Hough

**Re: AMA Position Statement on *Medical Training in Expanded Settings including in the Private Sector – 2007***

Thank you for providing the Postgraduate Medical Council of Victoria (PMCV) with the opportunity to respond to the AMA's Position Statement on *Medical Training in Expanded Settings including in the Private Sector – 2007.*

**Background**

As you will be aware, the PMCV has delegated authority from the Medical Board of Australia for the accreditation of Intern positions in Victorian health services and general practices, and also reviews and makes recommendations in relation to PGY2 positions. The PMCV further supports prevocational training through the administration of the Computer Match for Interns, HMO2 and Basic Physician Consortia Trainees; the activities of its subcommittees including the Junior Medical Officer Forum; and its professional development programs such as implementation of national programs including Teaching on the Run and the Professional Development of Registrar Programs.

In Victoria, intern positions have increased from approximately 450 in 2008 to approximately 700 in 2012, a 55% increase over 4 years. This expansion of internships has been undertaken via a staged process in Victoria, led by the Victorian Department of Health and supported by Victorian health services and general practices. Expressions of interest were invited from health services for additional intern positions, and applications received were jointly evaluated by the PMCV and the Department of Health.

The results of this showed that the target of 700 intern positions by 2012 had been achieved. A number of new health services had been accredited to take interns (both rotating and 12-month programs). All new intern positions included core terms, and a majority of new intern positions were located in outer metropolitan and regional public hospitals.

- Nearly 50% of additional intern positions were allocated to disciplines of (public) workforce shortage, including in particular general medicine, geriatrics & psychiatry.
- Ninety intern posts were allocated to rural/regional sites and the majority of these went to 12-month intern programs.
- A small number of innovative positions in expanded settings have been accredited during this period (e.g. addiction medicine, palliative care, forensic medicine, trauma, radiation

oncology, radiology, pathology, obstetrics & gynaecology), however the PMCV is aware that not all of these have been retained by health services for financial reasons.
- There has been a small but significant increase in PGPPP intern positions, with very small numbers of private and community sector placements (e.g Epworth Health).

I make some further comments in relation to the specific items raised in your letter:

- ***What are the core principles that should underpin medical training in expanded settings?***

I note that the definition of 'expanded settings' provided in the AMA Position Statement include '*smaller public hospitals, private hospitals, private practices, community-based practices and non-clinical settings.*'

The principles to support training in alternative settings listed in the 2007 AMA Position Statement (page 3) remain relevant in 2012. From an accreditation perspective, PMCV believes that core principles should underpin medical training no matter the site, although it is recognised that alternative settings may have additional requirements. Examples of core principles that underpin medical training include:

- High-quality, relevant learning opportunities for junior doctors, and adequacy of exposure to a range of clinical problems and clinical decision making (which includes ensuring support for the learners/trainees, good supervision and some quarantined time for learning).
- Continuity of care is critical for quality learning experience (especially in General Practice).
- Protected teaching time for learning (at least for interns)
- Professional development to support supervisors and/or General Practitioners who support the learners/trainees.
- Assessment and feedback, and appropriate support mechanisms for trainees who may be experiencing difficulties.
- Workload and employment conditions consistent with accreditation requirements.
  In the case of General Practice, parallel consulting and Engagement with the stakeholders that are integral to the craft area where the learning experience is based.

- ***What are strengths and gaps in current policy, process and practice in this area?***

A *process strength* has been the accreditation and monitoring of posts in expanded settings, ensuring that training quality has been achieved, however a *process gap* has been no additional resourcing for accreditation of the additional positions.

*Practice strengths* - The PMCV has seen examples of where prevocational training can be delivered effectively in expanded settings; these include small public hospitals such as in the 'Murray to Mountains' intern program which commenced in 2012; and private hospitals such as the Epworth Eastern surgical and medical intern positions (co-located with Eastern Health) which commenced in 2011 & 2012 respectively. In Victoria a number of prevocational general practice placements (PGPPP) have commenced in the last few years at both intern (approximately 18) and PGY2 level (approximately 20). PMCV recently accredited a paediatric PGY2 rotation in a community setting, and in principle supports expanded capacity in this area. All the examples listed above have provided opportunities for prevocational trainees to experience a wider variety of clinical practice and training opportunities.

*Practice gaps* - In practice, the number of prevocational training positions in alternative/expanded settings remains a relatively small proportion of additional intern/PGY2 placements. The main reasons for this are lack of funding that fully compensates alternative settings for prevocational training, and the lack of supervisory models and access to supervisors.

- ***What are the most significant factors likely to impact on medical training in expanded settings?***

*Funding* for intern & PGY2 positions has become an increasing issue in Victoria given the current tight fiscal environment. Lack of funding for the full cost of prevocational training is the major disincentive for private health services or community placements to consider taking prevocational doctors.

*Clinical supervision* & other support requirements for intern and prevocational programmes are extensive, and lack of expertise (in addition to lack of funding) may limit the capability or interest of private or community providers in moving into prevocational training. Additionally, lack of existing educational infrastructure or expertise may limit learning opportunities for prevocational trainees in these settings.

Additionally, primary supervision of prevocational doctors is being increasingly undertaken by registrars (or other more senior doctors-in-training) in public hospital settings, and private/community settings have indicated a desire to have this level of supervisory infrastructure in place before committing to prevocational training. Should performance assessment of prevocational doctors become more rigorous as a result of the Registration Standard for Interns, this would also require expertise and resources that may not necessarily be available in the private/community sector, and would by necessity reduce clinician time for clinical service provision.

*Facilities* may be also limited in alternative settings that do not necessarily have infrastructure to support postgraduate training, such as space for clinical practice (e.g. general practice consulting rooms), and other teaching and learning facilities.

*Resistance* by service providers may also limit uptake, where concerns that a focus on teaching may reduce the ability for service provision to meet demand.

*Lack of existing structured public-private/community partnerships* may also limit opportunities for the public sector to adequately support private/community placements.

It is also noted that there is an *accreditation burden* in relation to medical training, and Victoria is currently participating in a GPET-funded pilot to streamline prevocational and vocational general practice accreditation. It is hoped that the outcomes of the program will make accreditation and therefore placement of trainees less burdensome for general practice. However little attempt has been made to better co-ordinate or reduce the accreditation burden for hospitals.

- ***What needs to occur to enhance training capacity in expanded settings in the future?***

Unless the identified gaps are addressed, it is difficult to envisage that further expansion of prevocational training into the private and community sectors will occur for the reasons highlighted above.

A state-wide approach to training, led by the Department of Health, is needed to support clinical training in more diverse settings. Local partnerships need to be established between

public and private health services, and between public and community health services, that support a state-wide model. Such partnerships may share prevocational trainees, funding and supervision and support structures. The Department of Health's Clinical Placement Networks, funded through Health Workforce Australia, currently operate at the undergraduate level, and may potentially have a role in co-ordinating expanded postgraduate medical training places in the future. Educational champions also need to engage their colleagues in private and community settings, and need to have the support of the Department of Health to develop new placement opportunities. Dedicated significant funding also needs to be provided by the State and Commonwealth governments to support expanded placements in both hospital and community sectors.

Under a possible new scheme, the development of Community based Internships in Regional & Rural areas on a significant scale would allow students engaged in the 10 Rural Clinical Schools the opportunity to remain within the regions for their prevocational training.

**Conclusion**

This response has focused on prevocational training placements, within the current remit of the PMCV. Vocational training has perhaps been more successfully integrated into expanded settings, including large private hospitals. Additionally, new programs such as the Victorian Department's Rural Generalist Program (commencing 2012-13) supports prevocational and vocational training in smaller regional settings. These programs have generally been specifically funded (e.g. through specific registrar and practice funding), and often involve a formal relationship between the private/community setting and a major public hospital (such as a rotational relationship where administrative and supervisory support is provided).

Yours sincerely

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