

Early Streaming Into Specialty Training

2006

Amid intense debate about medical education and training and continuing concerns about a medical workforce shortage, there has emerged a push by some groups towards early streaming of medical students and graduates into specialty training. The AMA opposes early streaming and supports continued emphasis in the undergraduate and early postgraduate years on a well-rounded generalist orientation. This enables junior doctors to develop, through practical training and experience, the set of professional knowledge and skills which underpins their entire medical careers and readies them for the specialist vocational training offered by medical colleges.

Present Position

The policy of generalist training in the first two postgraduate years has been well thought out and endorsed by the Commonwealth and the States. This was done through the Medical Training Review Panel (MTRP), which was established under amendments to the *Health Insurance Act* in 1996 to compile and publish information on postgraduate training opportunities for doctors. There is broad and comprehensive representation on the MTRP not only of the medical profession, but of medical educators, employers and government agencies concerned with funding and delivery of health care services.

The MTRP working group formed to review the training needs of hospital medical officers (HMOs) made a series of recommendations including:

- full medical registration should be granted after completion of one year of supervised internship;
- emphasis in the first two postgraduate years should normally be placed on achieving a well-rounded generalist orientation in preparation for vocational training;
- the second postgraduate year should include sufficient options to allow vocational emphasis (some of which could be recognised by colleges), if desired by the HMO, but formal streaming into vocational training should not occur until the third year.

These recommendations were endorsed by the MTRP in 1997. They have formed an agreed national policy since that time.

When the Commonwealth funded the establishment of Postgraduate Medical Councils (PMCs) in 1998, one of the agreed outcomes was “that the first two postgraduate years be treated by all States and Territories and all medical colleges as generalist years in orientation with no formal streaming into vocational training programs, but with sufficient options in the second year to allow vocational emphasis, if desired by the individual HMO”. It was recognised that more structure and support were needed for this critical prevocational phase, enabling better integration and continuity with undergraduate education, postgraduate vocational training and the lifelong learning and development which is accepted as part of being a medical practitioner.

Under pressure to produce specialist doctors more quickly in a serious national shortage of doctors, several colleges have allowed and even encouraged junior doctors to enter their vocational training programs in the second postgraduate year. This arrangement suits many individuals, particularly those emerging from the graduate-entry medical schools with considerable life experience and financial commitments. Also, junior doctors may feel pressured to enter vocational training early because of the impending wave of additional graduates arising from the large increases in medical school intakes. However, while flexible and sensible responses to individual circumstances are to be encouraged, including College recognition of specific terms in the second postgraduate year, they should not undermine the current policy of having a period of generalist training and experience before entering specialty training.

Undergraduate Education and Training

In the debate about undergraduate medical education, there is a risk that too much attention will be given to the different phases of medical education and training and not enough to vertical integration of those phases. Undergraduate medical courses should not only enable doctors to meet the knowledge and skill requirements of their postgraduate jobs, but also provide a broad base from which the medical graduate can develop a career in any type of medical practice.

Medical education needs to be approached as a continuum and should not be fragmented. Learning continues throughout the career of a medical practitioner, building on the solid foundation of knowledge gained firstly from the undergraduate, then prevocational and vocational years. Undergraduate medical education which concentrates too much on the job competencies required by employers for their interns presents the risk of weakening the deeper understanding of underpinning knowledge and method that are the foundation of quality medical practice. The aim should be to produce exceptional doctors, not just average interns.

Undergraduate medical courses should provide a broad base from which the medical graduate can develop a career in any type of medical practice. It should also aim to produce junior doctors who possess the knowledge, skills, attitudes and potential to meet effectively the current and future health needs of Australian communities.

Undergraduate medical education should:

- i. include broad concepts of health, of health education and of the prevention of ill-health;
- ii. promote an understanding of human development, health and disease through the acquisition of knowledge of the appropriate physical, biological and behavioural sciences;
- iii. integrate the basic sciences with clinical and behavioural sciences;
- iv. provide an understanding of the importance of the doctor/patient relationship in medical care;
- v. value the apprenticeship model of medical education and use alternative teaching methods (simulation) as additional to this;
- vi. provide patient contact early in the medical course;
- vii. include teaching within and outside hospitals;
- viii. contain a component dealing with Aboriginal health;
- ix. early and continued exposure for medical students to rural practice;
- x. include elective terms;
- xi. teach research methods;
- xii. instruct students on peer review, emphasising its importance in medical practice;
- xiii. be structured on the premise that all stages of medical education are related, and that they will be followed by postgraduate training and continuing education in every discipline; and
- xiv. promote an awareness of the many aspects of law and ethics relating to medical practice.

Prevocational Medical Education and Training

Australia is renowned for producing high quality medical graduates. However, these graduates require a strong prevocational training experience. The AMA maintains the view that the prevocational period, the time between graduation from medical school and commencement of specialty training, is an essential time in the development of a junior doctor and must be valued and supported. This period is an important phase in the training of doctors to the high standards that have been a hallmark of medical practice in Australia.

Consistent with the multiple roles of a medical practitioner identified and defined in the CanMEDS 2000 project, the AMA supports a focus during the early postgraduate years on clinical skills development and medical professionalism. Induction into professional practice and development of those attributes/skills not specifically addressed during undergraduate medical training should provide a focus for this phase of doctors' professional careers. Training should be an apprenticeship which is patient focused and skills based.

Nobody wants to delay the making of doctors, but the complexity and subtlety of the process can be too easily missed in the rush to shorten training times and meet pressing workforce needs. Time spent with patients and with mentors cannot be replaced by fast track teaching methods. The growth of "medical professionalism", which underpins the vocation of medicine, occurs best across a range of settings and medical disciplines, so that varied streams of medical knowledge and practice can be related and understood as part of an integrated whole. Graduates need time to be inducted into professional practice and need time to develop those attributes and skills that only come from time spent with direct patient care and through mentoring by senior clinicians. Early streaming cuts short this time and thus compromises the quality of medical training.

It takes time for the majority of junior doctors to make a decision as to the specialty they will pursue. The 2005 AMWAC report 'Career Decision Making by Postgraduate Doctors,' revealed that only 18% of doctors decide by the end of their medical school training what specialty they will pursue. By the end of the intern year, when

doctors receive full medical registration and the right to practise medicine outside a closely supervised setting, only 36% have made that decision.

Most junior doctors need to have a range of experiences and be exposed to different medical disciplines and settings before making a confident, informed decision about their specialty training. This decision making time is important and should be preserved. Junior doctors need to be exposed to a variety of specialties, not only to assist them make robust career choices, but also to ensure that they gain the necessary general experience that will provide a sound foundation for their specialist careers.

Broad clinical experience is important in ensuring doctors have the knowledge and skills to treat patients in a holistic manner. Graduates need time to gain clinical experience and develop professional skills through direct patient care and mentoring before moving into vocational training. Early streaming into specialty training would not only remove a vital phase in the medical training system that has earned Australia a worldwide reputation for excellence; it would also cut across the reality of the way in which doctors make their career decisions. Especially with little recognition of learning and training across medical specialties, many doctors may find themselves locked into careers for which they are not really suited, with consequent implications for their participation in the medical workforce.

Medical Workforce

The 1996 provider number legislation, which required doctors to obtain a fellowship of a medical college for access to an unrestricted Medicare provider number, was the main driver for development - or reiteration - of a nationally agreed policy on a generalist orientation in the prevocational years. This important phase of professional and career development was seen as necessary grounding for entry into vocational training. There was also seen to be a need for a generalist medical workforce in hospitals to undertake much of the work involved in assessment, admission, diagnosis, treatment, monitoring and discharge of patients. Generalist prevocational training helps to meet this need.

Other factors in support of generalist prevocational training are the growing incidence of co-morbidities in an ageing population, availability of broader treatment options, emergence of “lifestyle” conditions such as obesity and diabetes and continued pressure on hospital beds causing shorter patient stays in hospital and more community-based patient care. The need for a generalist medical workforce continues to hold true even as medical education and training widens beyond public hospitals into private sector settings. Early streaming into specialty training works against that need.

The system of generalist prevocational training in the early postgraduate years produces a more flexible and adaptable medical workforce than early streaming would allow. Interns and Resident Medical Officers (RMOs) can be assigned to and trained in smaller hospitals which do not provide a wide range of specialist services but may be well equipped to provide generalist medical training with strong mentoring in the prevocational years. Early streaming into specialty training is likely to reduce the placement options of junior doctors, with particular effects on smaller rural communities which cannot support training placements in a wide range of medical specialties.

With governments having approved very large increases in the number of medical students in Australia, the AMA has strongly pressed the need for much more attention to clinical teaching resources and more intern and other postgraduate training places for the extra medical graduates. The delay in tackling the downstream effects of huge increases in medical school places has been a major concern. Finding enough well designed and supervised places to accommodate all medical graduates in the early postgraduate period will be challenge enough. Increasing College capacity and accredited places for vocational training is another set of challenges again. Early streaming into specialty training would exacerbate these problems.

There has been, and continues to be, much debate about reform of the health care system in Australia. Much of the talk is about breaking down traditional demarcations between health professionals and moving more to health care teams which, it is argued, can deal more effectively with an ageing population, chronic disease and preventive health measures. The AMA believes this can work if the health care teams are led by medical practitioners who, by definition, have the necessary training, knowledge, skills and understanding in holistic patient care. Early streaming of doctors into specialty training tends to work against this trend.

Efforts to address workforce shortages by fast tracking doctors into specialty training are likely to reduce the generalist medical workforce and create new health workforce problems without fixing the existing ones or improving the capacity to meet the future health care needs of the Australian community.

Conclusion

Doctors have to grapple all their professional lives with an ever increasing and changing array of medical knowledge, diagnostic methods and treatment options. It is little wonder that many doctors choose to specialise and the system has evolved accordingly into a range of specialties and subspecialties. However, there continues to be a need for the generalist medical training and accompanying development of “medical professionalism” which bind the medical profession and constitute a major reason for Australia’s international reputation for high quality medical training and practice. There is no reason to compromise that quality in pursuit of short term workforce goals.

Changes will inevitably be made to medical education and training in Australia, but it is important to retain the best elements of it. With this in mind, the AMA supports generalist training in the undergraduate and early postgraduate periods and opposes early streaming into specialty training at those times.

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