Best of Best

A maple leaf among the gum trees

Longer obstacle courses may not produce better doctors

Intern training is now formally under scrutiny. As part of a review commissioned by the Australian Health Ministers' Advisory Council (AHMAC) and led by Andrew Wilson and Anne Marie Feyer, a discussion paper was released in February this year that raised a number of questions and made a number of assumptions.[1] That paper mentions the Canadian experience, and hence the internship described below is salutary.

One intern's experience

Last year, one of the interns in my program in rural Victoria[2] was a Canadian who had undertaken her undergraduate medical training in Australia. She had done so because, unlike in Canada, here she was not forced to make an irrevocable decision about her future career during her medical school years. She came from the prairie province, Saskatchewan. She had reasoned that early postgraduate years in Australia would give her "the breathing space" to make a more informed decision about the career she wanted to pursue.

However, she did not need the full year to decide. Near the end of her internship she made up her mind — she wanted to become a rural general practitioner in Canada. Complementing her hospital rotations in surgery, medicine and emergency medicine, she had undertaken extensive community practice through the combined 20-week rotation in the Victorian town of Bright and in the nearby Mount Hotham snowfields. This experience had sealed her intention.

In the snowfields, the exposure to medical emergencies and the number of trauma cases provided a busy and intensive learning experience. She was one of only two interns in Victoria licensed to take x-rays. The environment reminded her of Canada, and the experience was so rewarding that she needed no more time to sort out her career. Paradoxically, having such a wide variety of experience enhanced her ability to make a career decision early.

Her experience provided several insights.

First, the surgical, medical and emergency rotations provided worthwhile experience. She did not feel that she was being harnessed as cheap medical labour.

Second, in Canada with only 2 further years of training she will obtain her rural general practitioner certificate. Her intern year in Australia was recognised as part of her Canadian postgraduate training.

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Third, one might ask: if the intern year satisfied the requirements for the first year of vocational training in Canada, why then would we encumber her in Australia, had she stayed, with a compulsory 4 years of vocational training before full registration? Turn the question around: does a well constructed intern year mean that vocational training could be shorter in Australia than it is at present?

Should hospital requirements come first?

The problem in Australia with not only the first but often the second postgraduate intern year is that the service requirements of hospitals have traditionally dominated the agenda. But if that service commitment is tempered by clear recognition of the educational value of these years, including community general practice experience as a component of a well constructed training program, then the first 2 intern years could surely contribute to specialty training programs.

The educational aspects of hospital-based programs for interns tend to abide by the requirements of the Australian Curriculum Framework for Junior Doctors (ACFJD). But the quality of an intern program should be defined by many features, including good organisation, innovative content, and the involvement of interested specialists, general practitioners, registrars and teachers who bring a high level of skills.

The Canadian intern appreciated the guidance and variety of experience of our program, which was innovative without infringing the ACFJD liturgy.

Longer is not necessarily better

The time taken to achieve a medical qualification is already long, but this has not stopped educators and others arguing progressively that more time is needed to achieve "full registration", and then even more to achieve "independent practice".

This phenomenon, which is as much sociological as economic, has been described in *Social limits of growth* by Fred Hirsch.[3] Increasing the length of required education achieves social scarcity. It does not guarantee more skills and knowledge. Hirsch describes this as "the wasteful lengthening of the obstacle course".

How might the intern years be made more useful for future practitioners?

The widespread introduction of a 20-week general practice rotation is a proposal worth exploring.[2] Where it has been implemented, it has increased the complexity of organising training, but it has been warmly received by interns. They feel value has been added to their internship experience without making it longer. Were this to become more common, the role of directors of clinical training becomes critical in building and maintaining the bridge between community practice and the hospital environment.

The importance or otherwise of directors of clinical training is not canvassed in the AHMAC discussion paper[1] — but it needs to be, as does the funding of such positions. Adequate supervision does not automatically follow just because the regulatory agencies deem it should be so. Nailing an Australian Health Practitioner Regulation Agency edict to the hospital board is not the solution. However, directors of clinical training who are appropriately resourced may be able to effectively interpret such edicts.

Nonetheless, innovation goes only so far, and funding is imperative for expanding internships into community practice. However, interns' patients are ineligible to claim Medicare rebates directly. The Prevocational General Practice Placement Program used to provide funding, but that program has ceased. There has been no replacement.

When I graduated, I was unequivocally registered from Day 1. If translated into today's world, that would mean eligibility for Medicare rebates for my patients. After all, the current intern already has a provider number; this is restricted to ordering tests, but what is the difference to allowing access to other areas of Medicare? If the government wants interns exposed to general practice then the government must pay for this experience, one way or the other.

In the end, the young Canadian doctor realised that she had had a firm base in generalist training. In Canada, she could progress more swiftly to a program tailored to be complementary. She also knew that it would take less time to complete her training. She has accepted a post in a small city in south-western Saskatchewan called Swift Current, where she will be able to put into practice what she has learned in Australia.

Lengthening time is not necessarily synonymous with acquiring greater expertise. What if one changed the metaphor and said expanding the time spent had a diluting effect? If so, further time spent in acquiring the right to practice independently without evidence as to its value could even have homoeopathic characteristics — perhaps like a drop of maple syrup into a firkin of eucalyptus oil.

Competing interests: No relevant disclosures. ■

1 Australian Health Ministers' Advisory Council (AHMAC). Review of medical intern training. Discussion paper. February 2015. http://www.samet.org.au/wp-content/uploads/2015/03/Medical-Intern-Training-Review-Discussion-Paper-February-2015.pdf (accessed May 2015).

2 Best JB, Boyer SL, De Lacy CJ, et al. Murray to the Mountains intern training program: involvement of small health services, *Med J Aust* 2015; 200: 378-380.

3 Hirsch F. Social limits to growth. London: Routledge & Kegan Paul, 1977. ■