An urgent challenge: new training opportunities for junior medical officers

Brendan J Crotty and Terry Brown

ABSTRACT

- There will be a massive increase in the number of medical school graduates over the next 5–10 years — there were 1287 Australian resident graduates in 2004, and there will be more than 3000 by the middle of the next decade.
- A workshop held during the 11th National Prevocational Medical Education Forum explored ways to provide the additional prevocational training posts that will be required.
- Four possible sites for additional training posts were discussed:
  - expansion of public hospital training posts;
  - general practice;
  - private hospitals; and
  - other sites, including private rooms and community placements.
- Current accreditation procedures will need to be amended to accommodate more interns.
- There will be limited access to prevocational training posts for non-resident (full-fee-paying) graduates and international medical graduates.
- There is an urgent need for postgraduate medical councils, state health departments, the federal government, and medical boards to work together to identify, develop and accredit new training posts.

MJA 2007; 186: S25–S27

Despite increasing demand for medical services, and reduced average working hours, the number of doctors graduating from Australian medical schools was relatively constant from the mid 1980s until the middle of this decade. To solve the problem of a worsening workforce shortage, 10 new medical schools have been established or announced since 2000.[1-3] There have also been substantial increases in the number of places in established medical schools. Graduate numbers will be further increased by the easing of restrictions on Australian resident full-fee-paying medical students; medical schools are now able to recruit up to 25% of the number of enrolled Commonwealth Supported Place (HECS) students as fee-paying students, in addition to publicly funded students.[4]

The exact number of Australian resident graduates entering the workforce over the next few years will depend on the enthusiasm of medical schools to expand full-fee-paying places. However, an Australian Medical Association briefing paper indicates it is clear there will be a massive increase, from 1287 Australian resident graduates in 2004 to more than 3000 by the middle of the next decade.[5] This paper predicts increases in all states, with the most significant relative increases in Queensland and Western Australia (Box).[5]

All graduates are required to complete an accredited intern year. The workforce shortage will not be overcome unless they are also able to complete postgraduate training programs. Professor Rick McLean from the Workforce Branch of the Health Services Improvement Division of the Department of Health and Ageing, a speaker at the 11th National Prevocational Medical Education Forum, estimated that the number of training posts will need to expand from 6000 to 12 000 to provide postgraduate training for all Australian graduates. In the communique from the July 2006 Council of Australian Governments (COAG) meeting, it was stated that the states and territories have agreed to provide intern training placements for federally funded medical students.[6] The Medical Training Review Panel has recently established a committee to tackle this issue.

Numbers of medical graduates and intern places in 2005, and predicted number of medical graduates in 2012

State	No. of graduates in 2005	No. of intern places in 2005	Predicted no. of graduates in 2012
NSW and ACT	443	566	944
Victoria	321	397	662
Queensland	276	280	760
WA	111	132	297
SA	150	171	265
Tasmania	47	52	95
NT	—	24	—
Total	1348	1622	3023

NSW = New South Wales. ACT = Australian Capital Territory. WA = Western Australia. SA = South Australia. NT = Northern Territory. ◆

A workshop entitled "An urgent challenge: new training opportunities for JMOs [junior medical officers]" was held during the 11th National Prevocational Medical Education Forum. This workshop explored ways to provide these additional training posts. The workshop was well attended by 70 junior doctors, medical education officers, supervisors of intern training, directors of clinical training, and members of postgraduate medical councils (PMCs) from all states and territories.

Potential sites for expanding postgraduate training

Participants were divided into groups to discuss four potential sites for expansion of intern (postgraduate year 1 [PGY1]) and resident (postgraduate year 2 [PGY2]) training:

- expansion of public hospital training posts;
- general practice;
- private hospitals; and
- other sites, including private rooms and community placements.

Each group was asked to consider the composition of the intern year. At present, state medical boards mandate core terms in general medicine and general surgery. In all states except South Australia, interns are also required to complete a term of emergency medicine — the duration of this term varies between

jurisdictions. South Australian interns can substitute a general practice term for the emergency medicine term. PMCs are already having difficulty identifying general surgery and emergency rotations, and it was agreed that it will be necessary to adjust the current requirements to accommodate more interns. Possible solutions include shorter rotations, accrediting subspecialty surgical terms (eg, orthopaedics or vascular surgery) as core surgical terms, allowing the emergency medicine term to be completed in either PGY1 or PGY2, allowing interns to complete a general practice term instead of all or part of an emergency medicine rotation, and using clinical skills laboratories to teach some of the procedural skills that would normally be learnt during an emergency medicine term.

The four groups also discussed the impact of increased numbers of medical school places on the doctors who are currently being used to make up the workforce shortage — non-resident (full-fee-paying) graduates of Australian medical schools and international medical graduates (IMGs). There was consensus that it was likely to become much more difficult for these doctors to obtain employment in Australia in the future. However, it was agreed that this did not diminish the urgent need to improve training opportunities for IMGs working in Australian hospitals.

Expansion of public hospital training posts

Participants from all jurisdictions suggested that most new training posts, particularly intern posts, will be in public hospitals. It was suggested that the public system could accommodate additional interns and residents by reducing working hours, providing opportunities for job sharing, using subspecialty units for core medical and surgery rotations, and creating new rotations in such areas as radiology, pathology, anaesthetics, and in non-clinical term rotations such as medical administration, clinical research and teaching. It was also suggested that there would be more use of generalist rotations in small rural hospitals staffed by general practitioners. Creation of additional posts in public hospitals will be an opportunity to review the balance between service and learning in prevocational training. Potential benefits include protected training time and elimination of rotations with excessive working hours.

General practice

Expansion of PGY1 and PGY2 general practice posts was seen as highly desirable, as most prevocational trainees currently receive very little exposure to the sector of the health system that cares for most of the population. This contrasts with the United Kingdom, where more than 50% of Foundation Year 2 (PGY2) doctors will complete a term in general practice.[7] Additional general practice placements could be provided by an expansion of the Prevocational General Practice Placements Program.[8] The main barriers to expansion are a lack of infrastructure to accommodate prevocational trainees (consulting rooms, computer access, etc), and a shortage of supervisors, exacerbated by demands for supervision of medical students and general practice registrars. Experienced nurse practitioners were identified as possible supervisors. Indemnity is a significant issue in New South Wales, where the state government has declined to indemnify junior medical staff working in general practice. PMCs are beginning to develop instruments to accredit general practice rotations.

Private hospitals

A small number of Australian private hospitals already offer intern and resident rotations.[9] Further expansion requires development of suitable models of supervision for sites where most medical staff are visiting medical officers and there are no registrars. Expansion may be limited by the willingness of governments and private hospitals to provide salaries and indemnity for junior medical staff. Private hospitals may be more appropriate for PGY2 trainees than interns. This would allow public hospitals to allocate interns to positions currently occupied by PGY2 trainees.

Other sites

During the forum, a number of presentations described innovative term rotations in community settings, including Indigenous health services, prisons, drug and alcohol services, and youth outreach centres. The workshop identified many other possible sites, such as residential care facilities, occupational health rotations in industry, ambulatory mental health services, crisis call centres, the armed forces, and state health departments. A large number of very suitable rotations could be provided in specialists' rooms if the Practice Incentives Program scheme was extended beyond general practice.[10] Funding, indemnity, accreditation, and identification and training of supervisors are problematic for all of these sites. Most are more appropriate for PGY2 trainees than interns, but once again, this could free up public hospital PGY2 posts for interns.

Planning for expansion

There has been very limited planning or consultation underlying the decisions to expand medical school places.[11] It would be highly desirable for the expansion of postgraduate training posts to be coordinated at a national level and integrated with workforce planning. Although there is little evidence of this at present, recent COAG decisions to develop national registration and accreditation programs may encourage PMCs, medical boards and health departments to develop a common national approach.[6] The lack of a uniform approach to accreditation of PGY2 posts, and more senior posts which are not accredited by medical colleges, is also a significant barrier to improving the quality of prevocational training.

Most PMCs and state health departments have already begun planning to expand prevocational training places. This is no small task. New posts and supervisors need to be identified and funded; learning objectives need to be developed for each new post; new positions need to be incorporated into hospital and health service rosters so that interns are able to meet the registration requirements of state medical boards; the new positions need to be accredited; and PMCs need to develop new accreditation instruments for positions outside the public hospital system.

The demands placed on workforce units in hospitals and state health departments and PMC accreditation committees will be considerable; they will clearly require additional resources. The current practice of using unpaid volunteers for accreditation visits may not be sustainable as the workload of accreditation committees expands.

There was general agreement at the workshop that the only feasible way forward is to expand the number of training posts incrementally over the next 5–7 years. However, there are currently many more accredited prevocational training positions than

local graduates, and this gap will increase until students of the new medical schools graduate.

PMC representatives from each state and territory were asked to summarise progress to date. All jurisdictions except Tasmania and the Northern Territory have some plans to expand the number of intern posts. However, there has been almost no planning to date for expansion of PGY2 positions or vocational training posts.

Western Australia is the only state that has developed a detailed plan to provide internships for all of the additional graduates from its medical schools. A joint committee with representatives from medical schools, the Postgraduate Medical Council of Western Australia, and the Western Australian Government Health Department has mapped out a gradual increase over the next 4 years. Most new training posts will be in public hospitals, but there will also be a number in the community and private hospitals. It is anticipated that the additional graduates will displace IMGs working as interns and residents within the Western Australian health system.

Planning in other jurisdictions is less advanced. Health departments and PMCs in Queensland and Victoria have developed plans for a stepwise expansion of intern posts to 2007 and 2009, respectively. The two governments have announced that they will provide enough intern posts for all Australian resident graduates of their state medical schools, but there are significant gaps between current plans and projected numbers of graduates in the early years of the next decade. PMCs in both states are actively exploring general practice placements for interns, and Queensland has plans to trial generalist placements in small rural hospitals. State governments in NSW and South Australia have also made commitments to provide intern posts for all Australian resident graduates of their medical schools, but there has been very little planning to date. As discussed above, general practice placements in NSW have been restricted by the government's decision not to provide indemnity. Tasmanian representatives reported that their state government has yet to release its plans to accommodate the increased numbers of graduates. Planning in the Northern Territory has been limited by the government's decision not to fund the Northern Territory Postgraduate Medical Council.

Conclusion

Planning to expand the number of intern posts in Australia has begun, but we are faced with a huge task to provide enough prevocational training positions for all graduates of our medical schools over the next decade. To date, there has been very little planning for the additional PGY2 posts that will be needed — or indeed for additional vocational training posts.

It will not be possible to identify, fund and accredit the required number of training posts unless PMCs and state health departments work closely together. It is unlikely that there will be enough traditional clinical placements in public hospitals. Thus, there is an urgent need for PMCs, state health departments, the federal government, and medical boards to develop new clinical placements in the public hospital system and in other settings, including general practice, private hospitals, small rural hospitals, specialists' rooms, and community health facilities. PMCs need to develop new accreditation instruments for these posts.

Acknowledgements

The workshop summarised in this article ("An urgent challenge: new training opportunities for JMOs") was sponsored by the Medical Indemnity Protection Society.

Competing interests

Brendan Crotty's registration and travel costs for the 11th National Prevocational Medical Education Forum — the venue for the discussion summarised in this article — were paid for by the Postgraduate Medical Council of Victoria.

Author details

Brendan J Crotty, MBBS, FRACP, MD, Head[1]
Terry Brown, MBChB, FFAEM, FACEM, Director[2]
1 School of Medicine, Deakin University, Geelong, VIC.
2 Postgraduate Medical Institute of Tasmania, Hobart, TAS.
Correspondence: hos-medicine@deakin.edu.au

References

1 Howard J, Prime Minister of Australia. More doctors and nurses for the health system. Media release, 8 April 2006. http://www.pm.gov.au/media/release/2006/media_Release1872.cfm (accessed Mar 2007).
2 Howard J, Prime Minister of Australia. More doctors, nurses and allied health professionals for Australia's health system. Media release, 13 July 2006. http://www.pm.gov.au/media/release/2006/media_Release2018.cfm (accessed Mar 2007).
3 Australian Government Department of Health and Ageing. Medical schools — more places. Fact sheet. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-medical_schools.htm (accessed Mar 2007).
4 Council of Australian Governments (COAG). Council of Australian Governments' meeting, 10 February 2006. http://www.coag.gov.au/meetings/100206/index.htm (accessed Mar 2007).
5 Australian Medical Association. Training and support for the future medical workforce: a looming crisis if left unattended. Briefing paper, August 2006. (Available from the AMA or the authors.)
6 Council of Australian Governments (COAG). Council of Australian Governments' meeting, 14 July 2006. http://www.coag.gov.au/meetings/140706/index.htm (accessed Mar 2007).
7 UK National Health Service. Modernising medical careers. Frequently asked questions. http://www.mmc.nhs.uk/pages/faq (accessed Mar 2007).
8 Australian Government Department of Health and Ageing. Prevocational general practice placements program. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-pgppp (accessed Mar 2007).
9 The Allen Consulting Group. Education and training of health and medical professionals in private hospitals and day surgeries. Report to the Australian Private Hospitals Association. Melbourne: The Allen Consulting Group, March 2005. http://www.apha.org.au/get/2417831080.pdf (accessed Mar 2007).
10 Australian Government Medicare Australia. Practice incentives program (PIP). http://www.medicare.gov.au/providers/incentives_allowances/pip.htm (accessed Mar 2007).
11 Crotty BJ. More students and less patients: the squeeze on medical teaching resources [editorial]. *Med J Aust* 2006; 183: 444-445.

(Received 8 Jan 2007, accepted 29 Jan 2007) ❑