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National Preparedness for Internship Survey 2017–2019

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Australian Me ed

Medical Boards Ahpra

A Joint Australian Medical Council and Medical Bo of Australia Survey

CONTENTS

We acknowledge all of our focus group and interview participants for their generous contributions to this report. Thank you to members of the Steering Committee and all external and internal reviewers for their advice and careful edits.

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[illegible]	The Confederation of Postgraduate Medical Education Councils committee which represents prevocational doctors in Australia and New Zealand. AJMOC focuses on educational, supervision and training needs of prevocational doctors.
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The Preparedness for Internship Survey has been delivered three times since 2017, so measuring long-term outcomes and impact is not yet possible. However, in this time, the survey has become a key quality improvement tool for most medical schools and some Intern Training Accreditation Authorities and health services. While some stakeholders took time to become fully aware of and embrace the survey and its results, many stakeholders have made specific changes, some structural, to their medical education and training programs which can be directly attributable to this survey. The AMC uses the survey results in its monitoring of accredited primary medical programs and, to a lesser extent, to inform accreditation assessments. Despite the relatively low response rate, the survey findings reports are considered high quality, and many stakeholders regard the information contained within them as informative and highly valuable in quality improvement. The AMC has engaged in new, complex processes and worked with a technically focused Survey Steering Committee in novel ways that have allowed for staff learning and development.

AMC staff implemented a continuous quality improvement approach to survey processes, as is demonstrated by the 2018 and 2019 process evaluation reports and by this evaluation. Despite these steps, issues and untapped potential have remained.

The most significant issue was the consistently low response rate. The survey managed a 20% response rate in 2017, declining to 16% by 2019. Because of the low response rate there is a reluctance by stakeholders to support integrating the survey more deeply into accreditation processes or to use survey results to drive change. This reluctance to use the survey results more directly leads to less robust quality improvement efforts connected to the survey. Due to this lowered willingness to use the survey to drive quality improvement efforts, the survey implementers had limited examples of changes made as a result of the survey. As survey respondents are often motivated by an altruistic desire to improve conditions for themselves or their peers, fewer quality improvement examples would likely result in a lower response rate.

Additionally, some stakeholders, particularly some senior medical school leadership, call for less than full transparency when publishing survey results based on the low response rate, which hurts awareness and usefulness of the survey among key stakeholder groups. Lower awareness results in fewer related efforts at quality improvement and means medical students and interns are largely unaware of the survey until they are asked to participate.

Survey communication – promoting the survey, distributing results, and explaining the purpose and outcomes – could also be strengthened. More effective communication is partially constrained by the need to maintain a balance between transparency and ensuring data is not misused or misconstrued. Greater engagement with an acceptance of the survey will not be achieved without implementing a robust strategy for increasing communication – perhaps including more widespread and creative sharing of results with a broader g1 ad and cr[illegible] of s

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These recommendations focus on possible quality improvement measures the survey implementing partners, the AMC and the MBA/Ahpra, could take.

Many of the recommendations are based on improving capacity to run the survey or other similar surveys in future, which has not yet been determined. Some recommendations relate to broader capacity.

The Preparedness for Internship Survey is designed to facilitate quality improvement and information sharing among medical education and training providers, chiefly medical schools, as well as to inform improvements in AMC accreditation processes. While the intended outcomes make clear that this survey is meant to improve access to information, holistic improvements to the transition between medical school and internship require the contribution of many stakeholders and a suite of tools and processes.

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1.1 Implement a new survey communication strategy, with a focus on building medical student and intern participation through wider awareness of the survey, its results and changes that have been informed by

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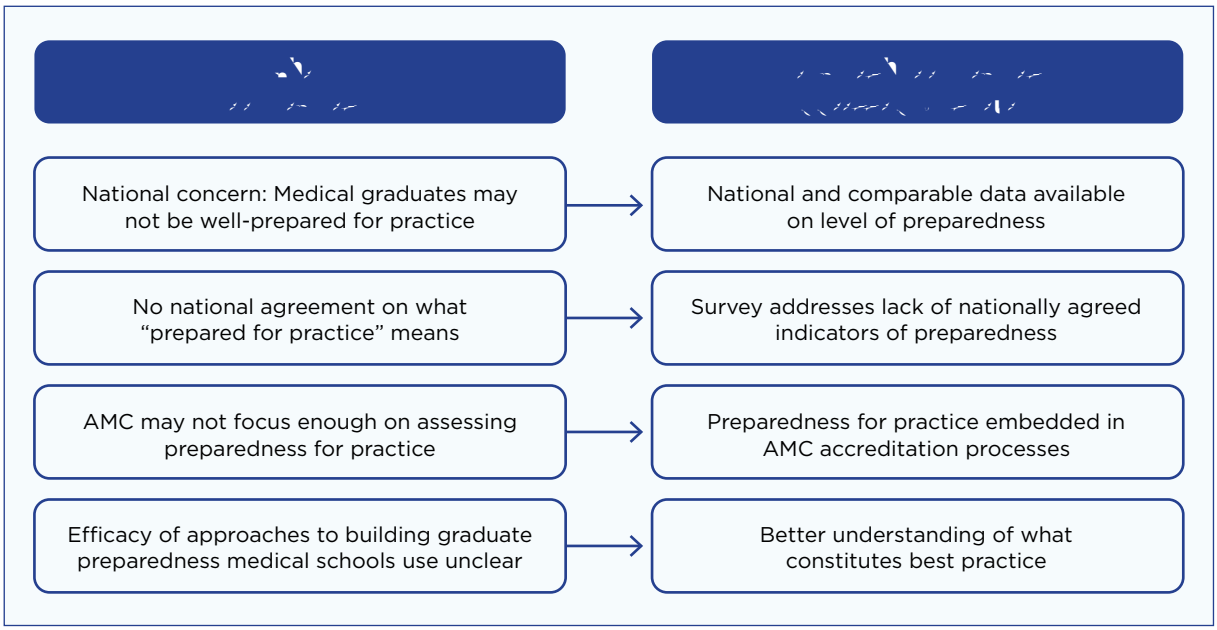
.1 Publicly clarify the validity of survey results, including by publishing correlations of the results with other valid outcomes data.

.1 Continue to address key-person risk by improving documentation around survey processes, including communication and analysis plans.

No specific recommendations.

1 Policy challenges and potential changes from conducting the Preparedness for Internship survey



After identifying the policy challenges that might be ameliorated by a survey, AMC Directors agreed to run the Preparedness for Internship Survey. The MBA/Ahpra agreed to partner with the AMC on the project. The AMC would manage a Preparedness for Internship Survey Steering Committee, design the survey, communicate with stakeholders and analyse the data; with the MBA/Ahpra emailing interns their unique survey link and contributing input into survey design and analysis. See Appendix 1 for the membership of the Survey Steering Committee and Appendix 2 for a description of the roles of the survey's implementing partners.

The Preparedness for Internship Survey Steering Committee was established to provide the AMC and the MBA/Ahpra with project oversight and technical advice. The survey was designed and programmed in Qualtrics software. At the start of the survey open period, Ahpra sent each intern a unique survey link via email, since Ahpra maintains a database of contact details of registered medical practitioners. Annually, the AMC developed a communication and analysis plan in consultation with the MBA/Ahpra. In 2018, the survey was complemented with several supervisor focus groups and a short supervisor questionnaire.

As AMC and Ahpra staff developed the Preparedness for Internship Survey, guided by the Steering Committee, formal outcomes were identified, and confirmed by AMC Directors and the MBA.

The core and secondary outcomes (also referred to as "aims" and "objectives") of the Preparedness for Internship Survey were identified at the onset of the project, and were later expanded upon by the Preparedness for Internship Survey Steering Committee. These outcomes are paraphrased below (Table 1).

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Although outcomes were set in 2017 and have been refined during the project, other components of the linear logic model were less defined and the Survey Steering Committee needed to consider the logic model in greater depth during the project evaluation stage. Elaborating a considered logic model makes for a more focused evaluation, including facilitating the identification of potential improvements to guide better implementation of the survey in future. Two levels of outcomes are identified with three associated timescales: short-term (<3 years), intermediate-term (3-5 years) and long-term (5+ years). The logic model is outlined in Appendix 3.

Secondary evaluation questions (SEQ) Evaluation Plan Methods Grid

1. What is the knowledge and acceptability of survey results by stakeholders?	Description of level of awareness of survey among stakeholders and language on acceptability of results (including development over time)	Document review, focus groups	Focus groups, medical school progress report submissions, past survey process evaluations
. Are there robust capabilities in the AMC to undertake, disseminate and analyse surveys as an accreditation tool?	Description of staff resource development in the period 2017-2020; list of survey-specific resources available in 2017 and 2020	Document review, interviews with internal staff and AMC affiliates, focus groups	Interviews and focus groups, AMC committee agendas and minutes
. Quantitatively and qualitatively, has there b[illegible]vailabl[illegible]			

There were 15 separate focus groups and interviews, which covered internal and external stakeholders including:

- Internal AMC staff
- AMC affiliates
- Leadership and peak body groups
- Representative groups

All interviews and focus groups were recorded and transcribed, and the transcription text was uploaded to NVivo for analysis. Both evaluators individually transcribed the interviews and focus groups. One evaluator undertook coding. Transcripts were read through completely and coded into the relevant evaluation questions, some of which were broken down further into descriptive categories.[7] The transcripts were also coded into basic thematic codes identified during internal discussion and transcription, including basic sentiment codes and different categories of limitations identified by participants.

Based on the evaluation questions a broad range of internal documents were identified by AMC staff and the Steering Committee as relevant, collected and uploaded to NVivo for analysis. These documents were:

- Medical school progress reports and accreditation report submissions from 2017-2020
  - All medical schools were considered except New Zealand schools and those without final year students in 2019 (four of the 23 medical schools accredited by the AMC). For these schools, none of their medical student cohort would have had the opportunity to respond to the survey
- Intern Training Accreditation Authority progress report and accreditation report submissions from 2017-2020
- Meeting minutes, agendas, and terms of reference of key AMC committees and working groups from 2017-2020, which were:
  - The Preparedness for Internship Survey Steering Committee
  - The Medical School Accreditation Committee (MedSAC)
  - The Prevocational Standards Accreditation Committee (PreVAC)
  - The MedSAC Standards Review Working Group
  - The AMC Intern Framework Review Working Party
- Relevant AMC Directors Items (identified by searching for key terms in AMC document management system)
- Preparedness for Internship Survey Process Evaluation reports, 2018 and 2019
- Preparedness for Internship Survey Intern Engagement Strategy 2020

Documents were reviewed in two ways. Documents that were wholly or mainly about the Preparedness for Internship Survey, including Survey Steering Committee minutes and agendas, and the 2018 and 2019 Process Evaluation reports, were read through completely for content relevant to an evaluation question. Any length of text within these documents that spoke to an evaluation question was coded into descriptive codes of evaluation questions. For some documents, only a small part of the overall content was about the Preparedness for Internship Survey. This would include, for instance, agendas of PreVAC, an AMC committee in which content related to the survey would have represented one item in occasional meetings. These documents were put through Text Search queries of key terms either generally related to the Survey or specific to evaluation question(s). Passages containing key terms were scrutinised to determine relevance to evaluation questions. Any length of text related to an evaluation question was coded into descriptive codes of evaluation questions.

7 For example, one code used was Key Evaluation Question 2: Changes to AMC accreditation processes and standards. It included several descriptive sub-codes, including "Medical school accreditation" and "Intern Framework Review".

A literature review was conducted to assess the peer reviewed and grey literature relating to

There was little evidence in document review or interviews and focus groups that the length of the survey, types of questions, or overall design were seen as a barrier to higher respondent engagement, though there were repeated suggestions that a generic survey link and survey links or reminders delivered by text message could be useful.

After the 2017 survey, the Survey Steering Committee specifically sought to reduce the number of questions in order to shorten the Survey. Nine questions were removed, and three questions were added, two with multi-part responses, for the 2018 survey. According to internal documents, the survey completion time consequently reduced from around ten minutes to five-seven minutes. Only one focus group participant pointed to survey length as an issue.

The Survey Steering Committee undertook minor survey content modifications annually, making

Survey management, particularly the timing and coordination of the survey with other surveys, is seen by some interview and focus group participants as a barrier to respondent and stakeholder engagement. Many of the issues participants pointed to have been considered and addressed by the Survey Steering Committee. See Appendix 4 for more detail on the survey cycle.

The timing of the survey open period changed from late August-September in 2017 and 2018 to May-June in 2019 (and planned in 2020). There were several reasons for the change in timing.

First, the Survey Steering Committee members and other stakeholders had an active discussion on the optimal time of year to survey interns on the theme of graduate preparedness. There was ultimately general consensus that the best time would be around the May-June period, when interns would be in their second term. A major driver for the survey's 2017 later timing was to address some stakeholders' concerns that they were not adequately consulted and were outside survey governance structures. Another reason for 2019/2020 change in timing was to avoid overlap with the MBA/Ahpra Medical Training Survey, which first ran between 25 July and 7 October, and is planned to be conducted annually in the August to early October period for the foreseeable future.

Several participants pointed out potential issues with survey timing, though there was no consensus on the best time of year:

> "Particularly towards the end of the year, you get a lot of survey fatigue, because you get the Hospital Health Check and the MTS when you're doing your registration, so I was just thinking in terms of this particular Survey whether it wouldn't be better to go out earlier?" (medical intern).

> "Would be interesting to know if the response rate would be improved if the survey is distributed at the end of the intern year rather than through the year. This is a time interns probably naturally reflect on the year and are more savvy with intern work" (intern supervisor).

Some focus group participants recommended greater coordination to avoid overlapping surveys and survey fatigue, which the Survey Steering Committee has kept in mind throughout the survey planning process:

> "[It] would be really terrific for a coordinated approach or at least give us lots of warning when you guys want to do these surveys, and when they're going to come out, so we don't end up asking for three things that are essentially the same at the same time" (medical school faculty).

There was also concern about the several months required to release findings, and how this might affect respondent engagement:

> "I think the elephant in the room is that we're dealing with digital kids who are very familiar with data collection but have an inexorable need to have it reported to them, they need instant feedback. So time taken to collate and analyse any Survey is going to be a negative reinforcement for next time people come to do it" (Intern Training Accreditation Authority representative).

like social media or a friend or a colleague and an email" (medical student).

"I'm happy to do survey, but... I think it's more that we get a lot of emails from the hospital... Like 10 or 12 emails a day. In one of them there is the "please do this survey". So I feel like it's less survey fatigue and more general email fatigue as well" (medical intern).

"Question: How do you think those results could be more effectively communicated, presented, and brought to junior doctors?

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The peer reviewed literature suggests that there are multiple methodologies that can be used to assess preparedness in doctors in training. In 2011, electronic surveys were used to assess intern preparedness in one Victorian health district. These were conducted at orientation and after second rotation and related to a list of 19 specific tasks.[12] Respondents detailed their medical school and their confidence in completing these tasks. In 2017, the longitudinal results of the survey which assessed perceptions of intern preparedness in various skills who attended the Launceston Clinical School were published. This is noteworthy given this was the survey from which the AMC/MBA Preparedness for Internship Survey was developed. In turn, the survey used by the Launceston Clinical School was developed from the Peninsular Medical Schools Survey in the United Kingdom.[3]

Prior to the introduction of the AMC/MBA Survey, medical schools often presented the findings of their own internal survey data relating to preparedness of interns. The University of Wollongong surveyed 100 interns over a five-year period at four to six months post commencement of internship for their thoughts around preparedness.[13]

Internationally, other methodologies have been used to assess preparedness. These include the use of a survey based on CanMeds framework which assessed supervisors' perceptions and graduates' self-perceptions of readiness, looking at the first cohort of graduates from a new medical school.[14] Other studies have focused on assessing junior doctor preparedness for specific skills like prescribing or describing changes before and after interventions targeted to improve specific skills.[15] Some conference presentations have described the use of focus groups with qualitative analysis of responses whilst others have utilised a mixed methods approach of surveys and focus groups. This research has featured interns or residents as the key participants, sometime including their supervising consultants and registrars.[16] Limitations of these studies include small participant numbers, a focus on discrete skills rather than the breadth of skills needed for practice, and limited geographic distribution of participants.

Peer reviewed publications and conference proceedings also describe how learners at other stages of the medical education and training continuum are assessed for preparedness. This includes longitudinal review of pre-clinical medical students' preparedness for clinical placement, surveys of current medical students immediately pre- and post-intervention, and various assessments of residents for preparedness to practice after attainment of Fellowship.[17] While more descriptive methods like focus groups or assessment of supervisors' perception of preparedness are sometimes employed, these are limited to either a specific facility or medical school, are not implemented across all medical schools in a national jurisdiction, or are focused either on one specialty in a jurisdiction or one specific skill.

12 Cate Kelly, Craig LF Noonan, and John P Monagle (2011) "Preparedness for internship: a survey of new interns in a large Victorian health service" 35 Australian Health Review 2, 146-151.

13 Kylie J Mansfield et al. (2017) "Preparation for internship: the outcomes of the Wollongong medical program" *Australian & New Zealand Association for Health Professional Educators Proceedings, Adelaide, SA 11-14 July 2017.*

14 Detlef R Prozesk et al. (2019) "Intern preparedness for the CanMEDS roles and the Dunning-Kruger effect: a survey" 19 BMC Medical Education 422.

15 Sheena E Geoghegan et al. (2017) "Preparedness of newly qualified doctors in Ireland for prescribing in clinical practice" 83 British Journal of Clinical Pharmacology 8, 1826-1834; Athena Michaelides et al. (2020) "Assessing the preparedness of foundation year 1 (FY1) doctors during the transition from medical school to the foundation training program" 20 BMC Medical Education 1; Michael J Nooromid et al. (2018) "Surgical interns: Preparedness for opioid prescribing before and after a training intervention" 215 American Journal of Surgery 2, 238-242.

16 Justin Tse et al. (2017) "Transitions. Perceived knowledge and skills gaps of interns in regards to medical school training" *Australian & New Zealand Association for Health Professional Educators Proceedings, Adelaide, SA 11-14 July 2017*; Justin Tse, Lauren Sanders, and Corinne Tey (2018) "Registrar/Intern Supervisors views and perceptions of work readiness of interns" *Australian & New Zealand Association for Health Professional Educators Proceedings, Hobart, TAS 1-4 July 2018.*

17 Renata R Urban et al. (2019) "Fellow Perceptions of Residency Training in Obstetrics and Gynecology" 76 Journal of Surgical Education 1, 93-98; C H Backes et al. (2016) "Preparedness of pediatric residents for fellowship: a survey of US neonatal-perinatal fellowship program directors" 36 Journal of Perinatology 12, 1132-1137; Rebekah Judge et al. (2019) "The role of a one week Transition Course in preparing students for Foundation Year 1: Views of medical students and Foundation doctors" *Association for Medical Education in Europe annual conference, Vienna, Austria 24-28 August 2019; Simon Field and Darrell Kyte (2019)* "Medical Students' Perceived Readiness for Clerkship - 5 years of Survey data" *Association for Medical Education in Europe annual conference, Vienna, Austria 24-28 August 2019.*

There was a general consensus that a survey of intern perceptions is the best tool available to provide a quantitative measurement of intern preparedness, though several interview and focus group participants indicated that additional perspectives, particularly those of supervisors,[18] would be a welcome addition to the survey:

> "When I last reviewed this literature, the tools that are available either continue to be a list of skills or attributes or things that you can do, or how confident or sufficient you feel about it, so it's a lot about self-assessment" (medical school faculty).

Some participants brought up a national licensing exam as another hypothetical tool to measure and benchmark medical school outcomes, but most indicated that it was not something they wanted to see introduced in Australia:

> "We'll [illegible] some [illegible]

4.1.

How is the AMC using the survey results to augment its accreditation tools, processes and standards?

- What is the result of the AMC's new practices internally and for medical schools?

Serving as an accreditation tool and critical piece of information for standards review processes was one of the key purposes identified for the Preparedness for Internship Survey (see Table 1). The potential value to medical school accreditation processes was reaffirmed after the 2017 survey was complete:

> "[The survey] revealed substantial and statistically meaningful variation in perceptions of preparedness, both within schools and across schools, and across skills groups. In doing so, the survey demonstrated it could provide a valuable input to accreditation processes" (AMC committee agenda).

AMC documents, including in statements of key outcomes, stated repeatedly that the survey findings would be used in the review of medical education and training standards:

> "Survey outcomes will inform the review of the standards for medical school programs and for the internship" (AMC committee agenda).

Even before the survey was finalised in 2017 (though after the National Work Readiness Forum survey in 2016), the Prevocational Standards Accreditation Committee noted the survey's "important implications for the review of the national framework for internship" (AMC committee minutes). As environmental scanning for the Intern Framework Review commenced in early 2019, the survey was pointed to as a key point of information.

Document review, interviews and focus groups show that the level of integration and use of the survey and its findings in accreditation and standards review processes

Other than in AMC monitoring, the medical school determines how deeply it wishes to report reflections on the survey results in accreditation submissions. AMC staff have begun providing a copy of the medical school's survey results to accreditation assessment teams as part of the broad reference material, but allow the team to determine how to use the results in assessing the school. AMC staff who support medical school assessments, AMC committee chairs, and AMC assessors, view the survey results as one of many pieces of data to consider, and regard AMC assessors as best placed to interpret that data in context:

> "[The school survey results report is used] as a soft indicator. It's provided to an assessment team, and sometimes it has been correlated with concerns for a school, but it hasn't been the only thing that has pointed to that. It's never been raised in the context of, 'your intern preparedness [survey results] say you don't do prescribing very well, what are you going to do about it'It has pe(w2nc) dos nea(y

> "[The survey] is an objective source and it is entirely plausible that in the future it may have more teeth, but certainly having been there at its birth I think it would not have got a lot of buy in from the schools because it does have measurement error" (Prof Geoff McColl, Chair Medical School Accreditation Committee).

There was also a suggestion from medical students that providing the results to students and student leadership as part of the accreditation process could help their own role in advocacy and quality improvement:[22]

> "[Holding medical schools accountable] could be something of 'hi medical society, here are the results of the Internship Survey, discuss them with your medical school because they're not doing very well.' Something needs to be done, and you need to close the loop of communication..." (medical student).

Interview participants indicate that the survey is also not currently used to make formal accreditation decisions or change the timing of an accreditation cycle.

The current medical school standards review is in its early stages, and it is unclear to what exact extent

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> "I think there is much more cooperation among medical schools in Australia over the last five-seven years to put their practices and processes up for scrutiny and up to national benchmarking. And the sorts of drivers for it [are] confidence in the AMC accreditation process…" (AMC affiliate).

> "Previously it sounded as though medical schools were quite defensive and then kind of mellowed out about [the survey] over time, and then saw some of the utility of it" (AMC staff).

Some medical schools appeared to be more critical of the efficacy of certain types of data than others (perhaps partly explaining why they do not make robust use of the results).

There are three typologies of how schools use the survey:

1. Schools that narrowly discuss the survey findings as one small, if interesting, piece of data among many. These schools will not use the findings directly to make large changes, though may use them as a piece of evidence that a change already under consideration should be made

One group of schools appeared to use the survey findings as, at most, a triangulating piece of data. For these schools, the survey findings may be interesting to consider, and they are required to reflect on the results as part of AMC accreditation monitoring[24], but they perceive that limitations weaken the usefulness of the data and/or that the data provide nothing new:

> "Whether it's one person or 50 people, it's always interesting to see what people remember or take away… The things that the students… from our school said about prescribing was completely what we expected, so there was nothing new in it, but basically it was confirming that we knew that we had a long way to go to lift it to a level we would feel was - what we would be completely happy with… So in that sense it didn't tell us anything new, it just simply confirmed what we already knew" (medical school faculty).

> "I think in response to the survey, [this student's medical school was] quite spooked by how poorly they ranked on Aboriginal and Torres Strait Islander health and had sort of overhauled that part of the course and they've actually, as we left the course sort of gave us almost a bit of an apology for not teaching us properly about that and tried to give us the classic 'here's a day of lectures to plug the hole that we need to fill', so that was very much in response to, you know various sources of information but the survey was something that they had talked about as a reason, and shared that with the entire [student] cohort, not in backroom meetings. It's been something that they've been really honest about, and trying to address as a consequence of the survey results" (medical student).

3. Schools that use the survey findings as a key informer of substantial changes to course structure and curriculum, in line with a planned major curriculum review process

A number of medical schools have fundamentally rethought the structure and content of their programs in recent years, particularly in transition from undergraduate to graduate entry degree

Interview and focus group participants and AMC documents point to two main contributions of the survey across the medical education continuum:

- Shifting and providing an evidence base to a conversation about the transition between medical school and internship

As canvassed in the 'Background and introduction' section of this paper, the creation of this survey was motivated by the Review of National Intern Training and the National Intern Work Readiness Forum identifying that some health services felt that medical graduates were not prepared for internship. A key outcome of this survey was that it provided evidence that interns did, in fact, generally feel well-prepared by their medical school program for internship. Although the conversation between the medical school and internship levels of the medical training continuum still "got a bit stuck down in the limitations of a survey", it also:

> "Gave us something concrete to talk about, so it did actually facilitate a conversation which would've been a bit more vague without the [Survey]" (Intern Training Accreditation Authority representative).

In addition, one Intern Training Accreditation Authority representative pointed to a shift in language from intern 'readiness' to 'preparedness' since the survey began:

Medical schools sharing results with intern training provider and supervisor representatives is another key way conversations are facilitated. Documents and interview and focus group participants indicate this appears to be widespread practice.

Medical school and intern training provider representatives repeatedly pointed out that it was difficult to sustain communication between the phases of the medical education continuum, and that informal personal networks were the most effective way of maintaining points of contact. Personal networks were necessary because formal fora do not exist, and also because key people were often not present in the collaborative fora that do exist:

> "It is difficult, isn't it, there's so much happening, it's just a bit bizarre really that there aren't those forums" (peak body representative).

> "As educators, we don't necessarily go to the health service and talk to the [representatives of supervisors] because they're hard to find, and [state health jurisdiction] doesn't necessarily share all their contact details - I have asked them before. Because we're interested in getting together to do that, but it seems to be on the individual basis, and individual relationships, and you kind of have to work hard to make those networks and connections" (medical school faculty).

The survey has also cast light on medical school-specific issues, and what could be done to address them, particularly through in-depth matrix questions on prescribing and Aboriginal and Torres Strait

Focus group responses from education providers describe the survey as being one of many data sources used in triangulation for guiding improvements.[31] Given this focus, it is unlikely that the survey would be mentioned in short conference abstracts or in peer reviewed literature which have been used for this review. The survey has been described in Australia Medical Association news articles promoting awareness to drive participation and also in response to survey findings.[32] As there has been no other national-level data on preparedness of interns described in the literature, there remains opportunity to develop a peer-reviewed publication from survey findings.

.1 Use the survey and/or evaluation results to contribute to the peer-reviewed and grey literature on graduate preparedness and the transition between medical school and internship. Present findings specifically at medical and health practitioner education conferences to facilitate knowledge translation.

31 See KEQ 3.

32 Australian Medical Association. "AMC/MBA Intern survey results released." Last modified 3 July 2018, accessed https://ama.com.au/e-dit/issue-154/articles/amcmba-intern-survey-results-released

Many medical students in leadership and student society positions report fairly strong engagement with the survey from their medical school, and schools report sharing with their students in committees:

> "We have various committees where the Survey is tabled, and each of those has a nominated student rep[resentative] or two, and they report back to the local student association" (medical school faculty).

> "I did some stuff with the education portfolio last year, that was the first time that I'd heard of the Survey, when they were going through results and looking how they might change the course as a result of it. And I guess, leaving the education portfolio this year and just general communications with the medical schools and general conversations we have, we don't use the words 'preparedness for internship survey'. I have seen some changes come through as a result of the Survey" (medical student).

However, there was at least one student who reported being specifically asked not to share the results with the broader student body by their medical school:

> "We spent a lot of time going through the Survey but there were some parts of it that we weren't very happy with the results, so it was obviously kept very quiet and wasn't shared widely with students because there were a few areas that we didn't perform well in" (medical student).

It is not clear how widely the results are disseminated down from the student leadership level, or if there is much interest among the student body to look at the results, particularly as currently presented.

This relative lack of awareness and general interest stands in contrast to the familiarity of medical students and interns with the Medical Deans Australia and New Zealand's (MDANZ) Medical Schools Outcomes Database (MSOD) and the Australia Medical Association's (AMA) Hospital Health Check surveys. There are different reasons for the high level of awareness between those surveys.

For the MSOD, medical student focus group participants reported that trusted local champions – usually senior faculty at medical schools – made personal and repeated appeals to students to fill out the survey, which medical students reported finding effective. In addition, medical school faculty point out that the MSOD targets medical students while still at school, so there are more opportunities to directly communicate with them and designate class time to complete the survey. Finally, the MSOD has been in place since 2004, meaning it is an established survey with high awareness among key stakeholders, and that MDANZ has had an extended period to engage in process improvement.

The Hospital Health Check, run by state AMA affiliates since 2015, is effectively communicated and extensively used in political and industrial relations between the AMA and medical training providers, meaning it is taken seriously as a tool of accountability and information source to choose training placements by medical students:

> "I think the AMA, the way that they promote their survey, it's quite well promoted in that it's on lots of different platforms. It's been running for a few years now and they're publishing good results and showing how people have improved how some people have gone backwards, and you can see continued sustained progress. So by the fact that they are having public accountability for the hospitals they can bring about change. Lots of people are really aware of it and even people who normally don't get involved in extracurriculars or people who aren't really involved in quality improvement or that sort of thing [get involved] because it relates to them and what hospital they are going to be in next year. There was personal buy in. They were quite interested in seeing the results" (medical intern).

Several interview and focus group participants indicated that they saw medical students and interns as a, if not the, key stakeholder, and suggested that results should be directly communicated and presented creatively to those groups by the AMC to facilitate their awareness and engagement.[33]

33 See KEQ 1.

Medical students and interns used and saw potential for greater use of the findings in quality improvement discussions between students and universities. To facilitate greater use of the survey by medical students and interns in quality assurance processes, however, there would need to be greater awareness of the results, possibly in the form of more direct communication from the AMC:

> "I think if [AMC] emphasise[s] actually getting results out to the focu[illegible]

What is the knowledge and acceptability of survey results by stakeholders?

- What are the barriers and enablers to achieve greater transparency/exposure of survey results?

The communication and presentation of survey results have gradually changed to allow greater and wider access to information among stakeholders since the survey was launched in 2017. The Survey Steering Committee has worked closely with medical schools, health jurisdictions, intern accreditation authorities, Medical Deans Australia and New Zealand, and the MBA/Ahpra to guide adjustments to results communication and presentation. While there are differences of opinion among these stakeholders on how to achieve effective transparency, there is general agreement that greater transparency promotes stakeholder trust and facilitates sharing of best practice.

Operating on a principle of increasing transparency, the following changes were made to reporting:

- In 2018:
  a. Medical school reports included all schools' response rates, an anonymised chart of average overall preparedness against all other schools, and the top three schools in each skill area
  b.

"I think all of the schools have gotten used to it. I think league tables are always fascinating to medical schools as they are inherently competitive. And I think it has been managed very well and it's been de-identified so you see where you are in the back. And that has been helpful… I think often the school reflects on their position in that rank and goes, 'oh okay fair cop let's have a little think about it'" (member AMC committee).

"I think some of the initial concerns that medical schools had were around league tables and things being published that would have really significant drawbacks for their school. I think part of what's helped is probably the way the information has been used [by the AMC] has not been… about a punitive thing and it's not 'this is better than that, these people are better than that', it's a piece of information that tells you about how people feel, and [illegible] been used [illegible] abo [illegible] h[illegible]

36 See KEQ 1.

There are divergent attitudes towards the public ranking of schools by ratings of overall and skill-specific preparedness. While medical deans and senior leadership have become more supportive of transparent benchmarking, medical school faculty responsible for medical education – who are often asked to account for their school's position in any 'league table' – were generally apprehensive, saying published ranking of schools would provide little added value and "doesn't make us collaborative" (medical school faculty). Medical students, on the other hand, were generally supportive, seeing comparative data as potentially facilitating healthy competition.

To gain support for greater transparency of results, then, it would appear essential to improve the response rate and to clarify the validity of results. Some tentative inferential analysis conducted by AMC staff in previous years showed that:

- Intern ratings of preparedness correlated strongly with supervisor ratings of preparedness (data from the 2018 supervisor focus group/surveys run in conjunction with the survey; findings presented in the 2018 survey results report)
- Intern ratings of preparedness to provide care to Aboriginal and Torres Strait Islander patients correlated strongly with accreditation outcomes (specifically, the numbers of Indigenous health-related conditions, recommendations and commendations issued to medical schools)

1.

.1 Publicly clarify the validity of survey results, including by publishing correlations of the results with other valid outcomes data.

Though there was a consensus that – not directly related to the survey – more resources were being put into strategic projects and building policy capacity, interview participants have a mixed view on whether the AMC has gained much in the way of new staff and affiliate skills that could be directly attributed to the survey. Some interview participants pointed to an increased level of sophistication in interpreting and analysing survey results, among staff preparing reports, and the committees and assessment teams scrutinising them:

> "...We were looking at a statistical approach, which generally is not a thing [within AMC accreditation]... So I do think it did develop a bit of capability there for a survey. I mean we had done surveys... but this was a much larger thing... I think it has added to the capability" (member AMC committee).

> "So I guess over time we have got a better appreciation of what pieces of information are potentially more useful. I think that clearly for something like [the Prevocational Standards Accreditation Committee], because we have had now three surveys to look at, we are developing a notion of what we think may be most useful in the survey" (Prof Andrew Singer, Chair Prevocational Standards Accreditation Committee).

One AMC staff member noted that the composition of the Survey Steering Committee had allowed staff to engage on technical survey issues with expert committee members. This helped with

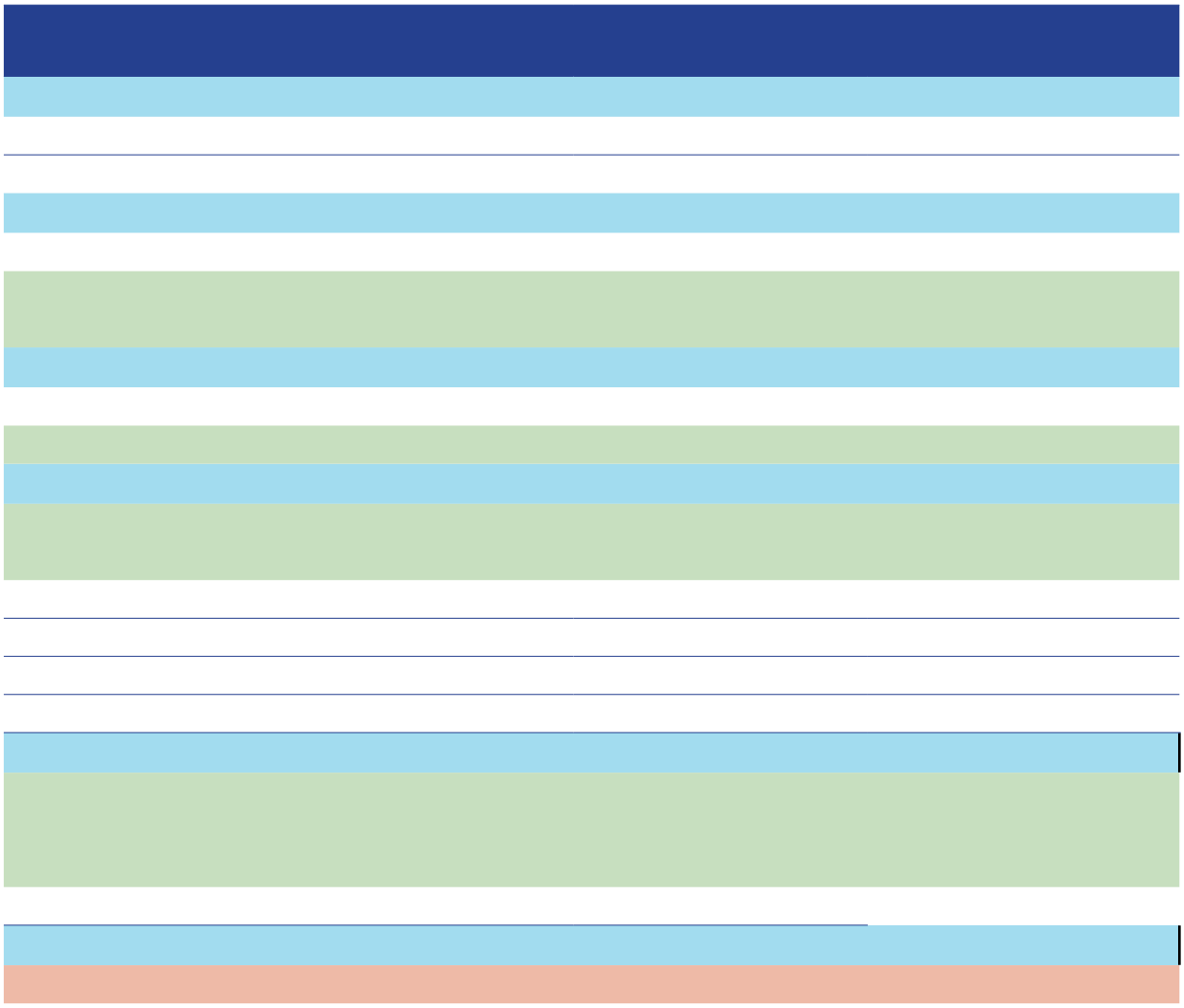
Quantitatively and qualitatively, has there been an improvement in intern perceptions of preparedness over time, whether globally or in specific (categories of) skills?

- Has there been an improvement in supervisors' perceptions of intern preparedness over time?

The Preparedness for Internship Survey provided strong evidence that medical graduates enter internship well-prepared in general as well as to perform a range of specific intern skills. Nearly three quarters of intern respondents agreed or strongly agreed that their "medical education was sufficient to undertake the role and responsibilities of an intern" in both 2017 and 2019.

However, the survey revealed that interns nationally felt less prepared to undertake some specific skills, particularly prescribing, some hospital system-related skills, and some self-management skills. Some of the qualitative comments also revealed particular dissatisfaction with training in cultural safety and providing care to Aboriginal and Torres Strait Islander patients at certain medical schools.

A key intended outcome of this survey is to support quality improvement by revealing areas of weakness, facilitating the sharing of best practice, and providing evidence to accreditation. However, these improved outcomes may take time to measure, because of the t0017 and Isturha,



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This evaluation report has presented the results of an outcomes-based evaluation of the first three years of the AMC/MBA National Preparedness for Internship Survey. The survey was implemented as a response to concerns about medical graduate preparedness. Over 2000 interns have participated in the survey in three years, and a broad range of stakeholders have contributed to its implementation and use. The survey has improved the accountability and quality of medical education and training at a key transition point.

The survey has seen success in improving general understanding of the state and drivers of intern preparedness, providing evidence to inform quality improvement by medical schools and intern training providers, and informing more data-driven accreditation monitoring processes. The evaluation elucidated issues with the survey process, particularly in the low response rate and communication strategy, as well as untapped potential in deeper integration of the survey in accreditation processes and use of survey results in peer-reviewed research.

The evaluation set out to answer five Key Evaluation Questions with the following findings:

1.

The relatively low survey response rate – likely driven by a communication strategy that did not focus on students and interns as key stakeholders – drove some stakeholders to engage poorly with the survey. Survey design, content and management issues were well-handled by AMC staff and the Survey Steering Committee.

The AMC integrated the survey into accreditation processes through new reporting in medical school monitoring submissions and AMC staff providing school survey data to accreditation teams. There was limited use of the survey in standards review processes, though these were ongoing and there were plans for further use. Some stakeholders argued that the survey could be more deeply integrated into accreditation processes.

Many medical schools enthusiastically used the survey to inform discussions and changes, including structural ones, to their programs. Intern Training Accreditation Authority and intern training providers indicated they did not make many changes to their accreditation processes or aining A1

Chair and member of the AMC Prevocational Standards Accreditation Committee

Deputy Executive Dean and Medical Dean in the Faculty of Medicine, University of Queensland

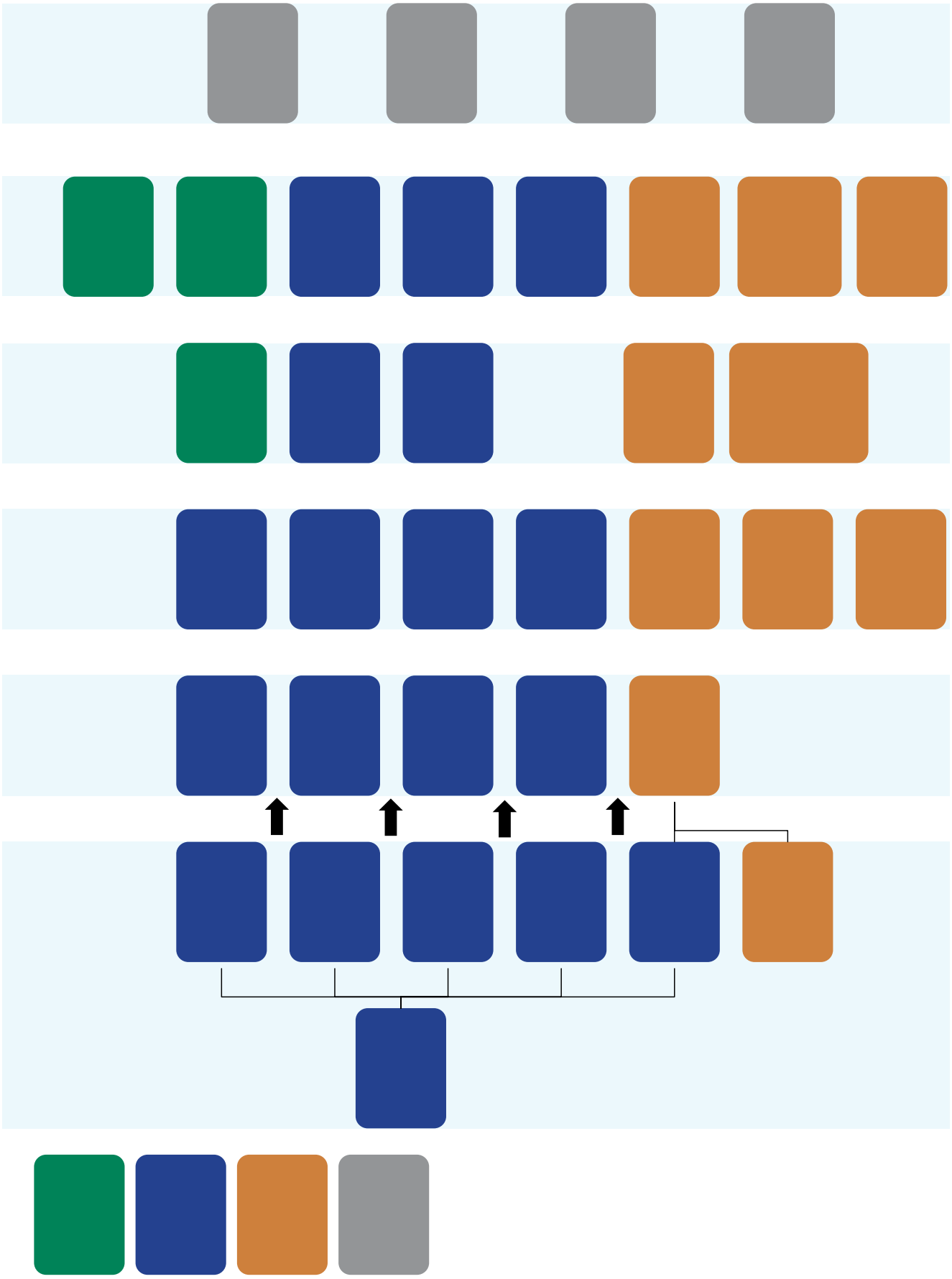
Director of Clinical Training, Princess Alexandra Hospital; Deputy Director, Peet

MBA/Ahpra:

- contribute to oversight and governance of the survey through the Survey Steering Committee
- help the AMC design the survey
- send all eligible interns a link to the survey, and reminder emails to all interns
- publicise the survey in the MBA monthly newsletter
- in cooperation with the AMC, publish a report of the survey results, without personal information, in a format and with contents to be agreed.

The AMC:

- manage the oversight and governance of the survey through the Survey Steering Committee
- design and conduct the survey
- receive the survey results, and collect, hold, use and disclose results in accordance with applicable laws
- own the survey results, and keeping results secure
- provide progress reports on the survey to regular meetings of the AMC and MBA/Ahpra
- analyse the survey results and compile these into a draft report that does not contain any personal information (that is, results are de-identified or aggregated so as not to disclose the identity of any individual or information from which an individual's identity could be reasonably worked out)
- only use the survey results for purposes related to the objectives of the survey
- in co-operation with Ahpra and the MBA, publish a report of the survey results that contains no personal information, in a format and with contents to be agreed.




MBA make decision to run