# Policy on Early Streaming

**Discussion**

Australia is renowned for producing high quality medical graduates. This quality is largely due to a long-standing tradition of generalist training in the undergraduate and early postgraduate years. These years allow for trainees to develop a high standard of medical professionalism, under mentorship from clinicians from a broad range of disciplines. Trainees acquire varied streams of knowledge and integrate these as a whole. This standard is increasingly important as the focus of healthcare in Australia shifts to a team-based, interdisciplinary approach.

The pressure to produce more medical specialists in response to an Australia-wide doctor shortage has led to fast tracking of trainees into specialty training. Junior doctors are able to access specialty training programs as early as PGY2. As an extension of this, streaming into specific disciplines may now start as early as medical school. This early streaming constitutes a threat to a generalist medical education.

Streaming may be contextual, where students undertake the entirety of their medical training in a specific setting, usually rural, or discipline specific.

**Policy**

1. In line with Australian Medical Council standards and the 1997 recommendations endorsed by the Medical Training Review Panel, AMSA believes that:
    a. Medical school training and prevocational medical training should consist of a broad-based, generalist education; and
    b. Medical school training and prevocational medical training should equip medical students and junior doctors with the basic knowledge and skills that underpin the entirety of their medical careers.

2. With respect to discipline specific streaming, where medical students are streamed into a specific vocation during medical school, AMSA believes that:
    a. Any attempt to fast track students and junior doctors through specialist training in response to workforce shortages should be avoided;

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b. Any specialty-specific curriculum or program that detracts from a generalist education should be avoided;
c. Discipline specific streaming may pressure students to make career choices early. Students should not be expected to decide upon their specialty choice in the formative years as choices may change from time in medical school to after graduation;
d. The implementation of discipline specific streaming creates inequity between students at medical schools that are well equipped to offer these programs, and those that are not; and
e. Medical schools should be discouraged from branding themselves as a discipline specific school.

3. With respect to contextual streaming, where medical students are streamed into a specific practice environment such as regional and rural, community and private practice during medical school, AMSA believes that:
    a. All students must be exposed to practice in a variety of settings during their training to ensure they receive an appropriate generalist education;
    b. The learning experiences available should be sufficiently broad such that graduates are qualified to practice in any setting upon graduation; and
    c. A student's decision to undertake clinical training in a contextual setting should be voluntary.

4. With respect to recognition of prior learning, where specialty training colleges recognise additional vocation specific study undertaken during medical school or prevocational years and commensurately reduce the length of vocational training time, AMSA believes that:
    a. It should be possible for medical students and junior doctors to use electives to undertake study in a discipline specific field of their choosing;
    b. The training colleges should be encouraged to reduce vocational training time taking into account the amount of appropriate discipline specific training undertaken prior to entry to the training program; however
    c. Any study undertaken in a discipline specific program, as part of a medical course, should not confer advantage for selection into a specialty-training program.

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