Fighting COVID-19: Enabling Graduating Students to Start Internship Early at Their Own Medical School

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As the United States is gearing up nationwide for the surge in patients from the COVID-19 pandemic, a major question on everyone's mind is, "Will we have enough doctors, nurses, pharmacists, and other health care providers?" Meanwhile, medical and other health profession schools have sent students home to keep them out of harm's way; to save precious personal protective equipment; and to decrease the number of persons who might function as vectors, especially those who are young and healthy.

Academic medicine nationally might take another approach. We could quickly prepare our graduating students for meaningful work at their home medical schools in anticipation of a time in the next few months when many health care providers will become ill. For the first time since World War II, we are having major societal disruption—but there is one major difference. Then, it was "all hands on deck"; now, we have more than 30 000 almost-qualified future interns mostly under stay-at-home orders.

Some countries, such as Italy, the United Kingdom, and Ireland, have already brought their students in as health care workers (1), and some U.S. medical schools, emulating New York University, have graduated their students early (2). During my years in academic medicine in Australia, I visited New Zealand and learned that final-year medical students work as "junior" interns. They work closely within teams, assessing patients, writing some orders, and testing out their skills as supervised members of the team, although prescriptions and other documents must be countersigned. They pay tuition but get a partial training subsidy. Except for graduating, they are expected to act as a doctor. Of importance, these students have been allowed to remain in health care during the COVID-19 outbreak because they are deemed essential (Poole P. Personal communication). If the United States were to follow suit, several important challenges would have to be addressed, including asking medical schools to verify student competence, that is, "readiness for residency"; compensating participating students; and rapidly addressing system challenges, such as supervision and credentialing. Here, I focus on medical students and physicians, but the principles may apply to graduating students in other health professions.

In April, the work year for U.S. health care graduates begins in late June, only 3 months from now. We might argue that it will be tough enough for new interns to function in July without the current stress of COVID-19. However, we could couple new online educational tools with the advantage of familiarity in having students start their "internships" in the health care systems affiliated with their medical school. First, medical schools could point students toward existing "readiness for internship" content. Many medical schools have a "capstone" course in the final weeks before graduation that prepares students for internship, with content geared toward meeting common patient care challenges. Most schools could deliver much of that content online now or via specific programs (3–5). In addition, some commonly required certificate courses, such as Advanced Cardiac Life Support and Pediatric Advanced Life Support, can be completed online in less than a week (6).

The United States could provide loan repayment or other federal payment programs for any senior students willing (and competent, as judged by their medical school) to begin early. The average U.S. medical student graduates with approximately $200 000 of debt (7), so generous repayment programs would be welcome—and fitting—with potentially less bureaucracy than officially hiring students through health care systems short term. An alternative would be to pay the students a stipend equal to a tuition rebate plus the equivalent of a resident's salary funded by Medicare (8).

Further, delays in transition to residency for this year's students due to chaos, credentialing, and other barriers might generate more problems for graduating students and short-staffed health care systems. We should urgently prepare these all-but-graduated students to help us address the looming workforce shortage as junior physicians during the next few weeks. However, they also should get credit for the experience they will gain and the service they will provide.

The last big advantage of this plan is that the new junior interns would be working on home turf rather than adjusting to a different hospital or place, as happens for many interns who move across states, or across the country, to start in different health systems. Starting at their home institutions would vastly decrease credentialing and barriers to electronic health record access.

We would have to rapidly address financial and logistic issues. Potential guarantees for loan repayment and tuition refunds would be key to success. Health profession schools would have to signal which students have the competency to begin working with more independence and agree to supervision requirements similar to those for residents. Supervision might be expanded to appropriate recently retired physicians or

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those whose health risks due to COVID-19 make them unable to work on the front lines. Health systems would need to authorize access so that competent students could write orders and access electronic medical records from home. Graduate medical education (GME) leaders would need to discuss potentially giving participating students "credit" toward residency completion.

These are bold but relatively straightforward requests, which I am certain academic medicine could tackle nationally in concert with GME leadership. Breaking down bureaucratic barriers must be a priority—a national effort could save many thousands of lives, not to mention being a substantial uplift for exhausted health care providers. Despite the logistic challenges, definitive and organized collective action now may give the United States an edge that we desperately need in this fight.

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