The Royal Australian College of General Practitioners

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15 September 2011

Executive Officer
Medical Board of Australia
Via email: medboardconsultation@ahpra.gov.au

Dear Executive Officer,

Re: Proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.

The Royal Australian College of General Practitioners ("the College") thanks the Medical Board of Australia for the opportunity to provide comment regarding the draft proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.

The College respectfully encloses its submission regarding the proposed registration standards and hopes that the recommendations made in this submission will assist the Medical Board of Australia in its deliberations of the proposed standards.

If you have any questions or comments regarding this letter, please contact myself or Mr Roald Versteeg, Manager – Policy & Practice Support

Kind Regards

Claire Jackson

Dr Claire Jackson
President
RACGP

The Royal Australian College of General Practitioners

RACGP Submission to the Medical Board of Australia

Proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training

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14 September 2011

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Medical Board of Australia for the opportunity to review and comment on the proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

This submission is made in response to the Medical Board's invitation to provide comment on the proposed registration standard as published on 12 July 2011. The proposed standards can be found at: http://www.medicalboard.gov.au/News/Current-Consultations.aspx

2. Executive Summary

The RACGP conditionally supports the introduction of nationally consistent registration standards for graduating interns, provided the quality of the training experience is not compromised by the proposed changes to existing registration standards.

The College also supports increased flexibility in the training program and a greater emphasis on the type of experience gained, particularly if there is opportunity to increase interns' exposure to general practice, and primary health care more broadly.

Opening up the primary care sector for intern training purposes will both significantly increase the clinical training capacity of the Australian health care system, and address the rising health care costs, inefficiencies, and fragmentation of patient care associated with the growing number of medical subspecialties[1].

However before this can occur more investment is required to address the financial, infrastructural and human resource constraints currently limiting general practices' training capacity.

With regard to the proposed move away from terms in *general medicine* and *general surgery* to accommodate the increased number of interns, the College seeks clarity as to the intent of the change. The RACGP is concerned that the changes may lead to variable and limited clinical experiences for interns, while still allowing them to qualify for general registration.

The College also seeks clarification regarding the proposed changes to the *emergency medicine* requirements. Although it is recognised that some general practices, particularly in rural and remote settings, may be able to offer significant emergency medicine experience, the College is keen to see details of how general practice posts, for the purposes of emergency care, will be determined as appropriate.

In relation to part-time training, the College seeks clarification of the Medical Board of Australia's intentions, as it is unclear as to whether the Board is looking at discontinuing time based training and making competency based training a salient feature of future training programs.

Lastly, in regards to overseas experience, the College would support this undertaking provided that the clinical placements are assessed and accredited by the appropriate authorities.

3. RACGP response to the Medical Board of Australia

It is understood that the proposed registration standards aim to achieve national consistency in the intern year and increase flexibility in training to:

- enable training for increased numbers of medical students
- address medical workforce needs.

In what follows, the College provides comment on the perceived opportunities and challenges posed by the proposed registration standard for graduating interns across eight key topic areas:

- national consistency
- increased flexibility and greater focus on experience gained
- funding implications
- international medical graduate training opportunities
- the risks to *general medicine* and *general surgery*
- emergency medicine versus emergency medical care
- part-time internship
- overseas experience.

3.1 National consistency

Overall the RACGP supports the introduction of nationally consistent registration standards for graduating interns, on the provision that the quality of training experience is not compromised by the proposed changes to existing registration standards.

3.2 Increased flexibility and greater focus on experience gained

The RACGP supports increased flexibility in the intern training program and a greater emphasis on the type of experience gained, particularly if there is opportunity to increase interns' exposure to general practice, and primary health care more broadly.

Opening up the primary care sector for training purposes will both significantly increase the clinical training capacity of the Australian health care system, and address the rising health care costs, inefficiencies, and fragmentation of patient care associated with the growing number of medical subspecialties.[2]

General practice (which is by definition the provision of person centred, continuing, comprehensive, and co ordinated, whole-person health care to individuals, families, and their communities) is proving to be a cost effective alternative to traditional training placements in hospitals.[3 4 5 6]

The lower health care costs associated with general practice are achieved through health promotion [7 8 9] disease prevention, and chronic disease management[10] in community based settings, involving fewer resource intensive clinical interventions, thus reducing the need for more costly elective and emergency hospital admissions.[11 12 13]

Hence, reinforcement of the general practice workforce is central to the delivery of cost-effective health care to the entire patient population, across all demographic groups, particularly those experiencing health disparities due to a range of socio-economic inequalities.[14 15 16]

Further, the team based model of care, involving multi-disciplinary primary health care professionals has the capacity to help address Australia's healthworkforce shortages by re-distributing the clinical load throughout the network of integrated primary health care providers.

The College notes that experience in general practice is an optional extra. That is, interns may undertake '*a range of other approved positions… in additional areas, such as, but not limited to, aged care, anaesthesia, general practice'…* among others.

Whilst the RACGP agrees mandatory terms in general practice are not yet available, the College believes that internship in general practice needs further consideration to enable interns to benefit from the curricular potential greater exposure to general practice, and the broader primary care sector may yield. The College believes that the proposed standards changes provide an opportunity to explore this potential, and would encourage such an interpretation to be more explicit in the final standards draft.

3.3 Funding implications

If intern training is to be pursued in general practice settings the existing financial, infrastructural, and human resource constraints need to be addressed. Governments will need to match the type of investment that has been made to support intern training and supervision in acute care settings.

This may involve consolidating and building on the separate streams of government funding currently available for training purposes as well as centralising the administration of existing funding programs to improve coordination of resources.

The RACGP is keen to work with the Medical Board of Australia and the government to strengthen the training capacity of general practice in the future, particularly in terms of downstream savings this may achieve in hospital expenditure.

3.4 Risks to general medicine and general surgery

The College is unclear about the practical implications of what appears to be a definitional shift, dispensing with the existing requirement for interns to complete terms in *general medicine* and *general surgery*, to accommodate the increased number of interns in the less specifically defined areas of *medicine* and *surgery*. Surgery, for instance, is currently a specialty, while medicine is a very broad generalism. Channeling increasing numbers of interns into a specialty and a generalism so early in their careers is likely to lead to highly variable and also highly limited clinical experiences for interns, while still allowing them to qualify for general registration.

The College is of the view that interns, as much as possible, should have exposure to a wide range of undifferentiated health complaints, typically handled by medical generalists. This allows trainees to develop crucial skills in clinical investigation, reasoning, problem-solving and decision making, while dealing with the inherent uncertainty and risks associated with such clinical presentations.

As they currently exist, *general medicine* and *general surgery* cultivate an understanding of the spectrum of health complaints including their complexity, the inter-relatedness of presenting symptoms and underlying causal factors, and how to take responsibility for managing health problems, across all interactive body systems, including their psychological dimensions. They are well understood and defined.

If the terms *medicine* and *surgery* in the new standards were defined as being more general than *general medicine* and *general surgery* – that is to say, less confined to current hospital rotations in these disciplinary areas – then the greater flexibility could lead to partial completion of these requirements in procedural general practices, or general practices with high general medicine throughput.

This problem will only be exacerbated in rural and remote settings, if all of the terms in *general medicine* and *general surgery* are reserved for entrants to the rural proceduralist training programs. If this were to happen, those who still wish to work as rural general practitioners, outside such programs, or in proceduralist settings, will be disadvantaged if their clinical experience is limited to practicing in specialty areas.

Lastly, if their definition leads to the streaming of interns into hospital-based specialties to the exclusion of general practice, the opportunity to leverage of the evidence-based benefits of the primary care sector will be lost.

3.5 Emergency medicine versus emergency medical care

It is understood that the term in '*emergency medicine*' will be replaced with a term in '*emergency medical care*' which will include '*a term in emergency medicine, or general practice, with exposure to emergency medicine*.'

The College seeks clarification regarding the proposed changes to the *emergency medicine* requirements, and notes that the '*suitability of posts to satisfy these requirements is to be assessed against guidelines issued from time to time by the Board* and that '*not all general practice posts will meet these requirements.'*

As general practices are not typically set up for this purpose, it seems inappropriate to create additional requirements for general practices without careful consideration. The RACGP should therefore be consulted on this matter before further action is taken, as the College has extensive experience in setting standards for the education, training and accreditation of clinical training posts.

While the RACGP agrees that there are some general practices that will be able to provide interns with significant exposure to emergency patient care, it goes without saying that there are benefits to having terms in emergency medicine.

The College is keen to see details of how general practice posts, for the purposes of emergency care, will be determined as appropriate and looks forward to working with both the Medical Board of Australia and ACEM regarding this important issue.

Lastly, it is uncertain why the minimum requirement for emergency medicine (8 weeks) is less than the requirements for medicine and surgery (10 weeks). Regardless, given that the minimum proposed emergency medical term will only be 8 weeks, it is important to ensure maximum exposure to emergency medicine within that period. It would therefore be inappropriate for interns to take their 4 weeks annual leave during such a term.

3.6 Overseas experience

Allowing interns to undertake clinical training placements overseas has the potential to increase the pool of appropriate clinical placements available to Australian interns provided that the nominated placements are properly assessed and accredited by the appropriate authorities. There will need to be quite objective and transparent criteria for assessing which posts will be regarded as suitable.

4. Concluding comments and recommendations

The RACGP recognises the need to meet the stated aims, and conditionally supports the introduction of national consistency and increased flexibility, particularly if there is opportunity to expand internship experience gained in general practice and the primary care sector more broadly.

However, for this to occur there needs to be a proper review and reinforcement of the resources dedicated to training activities in general practice.

Looking more broadly at the wholesale changes, the College has some concerns about the means by which the Medical Board of Australia is proposing that the stated aims be achieved, particularly if there is:

- a move away from experience in '*general medicine*' and '*general surgery*'
- re-definition of what constitutes 'emergency medical practice'
- inadequate assessment of training posts for attainment of overseas internship experience.

Therefore the RACGP recommends that further consultation be conducted to address these issues and refine the proposed standards before proceeding with implementation.

5. References

[1] Barbara Starfield, MD Keynote Address Divisions of General Practice Network Forum Perth, Australia November 4, 2005

[2] Barbara Starfield, MD Keynote Address Divisions of General Practice Network Forum Perth, Australia November 4, 2005

[3] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. The Millbank Quarterly, vol 83, no 3, 2005, pages 457-502.

[4] Controlling for income inequality, a 20% increase in the number of primary care physicians is associated with a 5% decrease in mortality (40 fewer deaths per 100,000). The effect is greatest if the increase is in family physicians. One more family physician per 10,000 (estimated 33% increase) people is associated with 70 fewer deaths (estimated 9% decrease) per 100,000. In contrast an estimated 8% increase in the number of specialist physicians is associated with a 2% increase in mortality. Barbara Starfield, MD Keynote Address Divisions of General Practice Network Forum Perth, Australia November 4, 2005 Source: Calculated from Shi et al, J Am Board Fam Pract 2003; 16:412-22.

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[16] Shi L, Starfield B. The effect of primary care physician supply and income inequality on mortality among blacks and whites in U.S. metropolitan areas. Am J Public Health 2001;91:1246-50.