Response to the Proposed Registration Standard

NSW Clinical Education and Training Institute JMO Forum

The Junior Medical Officer (JMO) Forum of the NSW Clinical Education Training Institute (CETI) thanks the Medical Board of Australia for the opportunity to feedback. The CETI NSW JMO Forum Chair circulated the paper to all NSW doctors in training for comment. This response summarises concerns and suggestions from the junior medical officer workforce of NSW. The appendix contains a selection of de-identified responses received by the JMO Forum about Emergency training. There was an overwhelming concern specifically regarding the proposed changes to the Emergency Medicine term standards, and about international rotations (which have been presented to the MBA previously).

Summary of Recommendations: "*General Requirements*"

- That the standard make provision for those states better able and resourced to provide a higher standard of intern experience rather than encouraging them to drop to a consensus level.
- That the national standard empowers state based Postgraduate Medical Councils to set network and hospital standards for intern rotations based on a local assessment of capacity and resourcing.
- Responsibility for accreditation of rotations according to the national standards should be identified as belonging to relevant pre-existing state and territory bodies.
- The Australian Curriculum Framework for Junior Doctors should be adopted to ensure standardised skills and knowledge acquisition in core terms.
- Core term definitions must include appropriate rostering balance to ensure adequate supervision and teaching within normal working hours are not sacrificed to service provision.

Summary of Recommendations: "*Specific requirements*"

- The guidelines must define the characteristics of terms that are required for accreditation, and must nominate the governance body responsible for accreditation.
- Newly created expanded setting terms must not count as core terms unless they meet the predefined standards for medical or surgical terms.
- The guidelines must clearly define the '*particular circumstances'* which permit overseas training to be accepted, including specific countries and duration of training. The standard must specify that these rotations would be optional not mandatory. International placements must have a comprehensive accreditation process outlined, and the '*Australian standard'* by which international rotations will be accredited must be specifically defined.
- In all states and territories, a quorum of suitable sites for GP placement with adequate emergency medical care exposure could be identified, accredited and adequately funded prior to adoption of a national standard incorporating them as a key provider of core training terms.
- The definition of '*exposure to emergency medicine'* must be clearly quantified.

- That all guidelines for accreditation of "Emergency Medical Care" posts be distributed for further consultation prior to adoption.
- An Emergency Medical Care rotation should have minimum duration of 10 weeks with at least 50% of duration of the term spent in a hospital Emergency Department under close supervision by at least one FACEM supervisor,
- That the components of an "Emergency Medical Care" term be expanded to include locations other than public hospital emergency departments and general practitioner placement.
- The guideline must specify that any accredited Emergency Medicine Care rotation must demonstrate appropriate case mix and supervision, and must define the case mix.

Discussion

Medicine and Surgery

Clinical exposure in an accredited medicine or surgery rotation with a minimum 10 week term reflects current practice, and many interns are currently rotating through specialist rather than general medical and surgical terms. The new draft standard provides an opportunity to broaden the generalist exposure of doctors in training.

The lack of specificity in phrasing in the standard may lead to a dilution of experience, particularly in terms of clinical supervision. For example, by incorporating after hours shifts into a standard surgical rotation roster, there is a significant risk of rostering for service provision, with minimal supervision or access to protected teaching, and reduced opportunity of comprehensive knowledge of the patient journey and acquisition of appropriate skills e.g., ward rounds, theatre time, discharge planning.

Similarly, a medical rotation with significant time spent in an ambulatory care component will result in a far different learning experience than a purely hospital based rotation. A geriatric medicine rotation with outpatient clinic weighting and a hospital based cardiology term will result in the acquisition of far different skills and knowledge and cannot be considered to be equivalent as core training.

Hence, whilst accepting that there is need to expand the locations of prevocational training, categorisation of such expanded settings should be carefully examined.

The concern is that the 'grey areas' of the standard with regard to core terms in medicine and surgery have the potential to allow compromise and dilution of clinical training.

Additionally, the standard makes reference to '*approved accreditation standards'* without specifying if these are to be national or state standards.

International Training

The issues surrounding international internship are multifactorial. At present there is no '*Australian standard*' to prospectively approve and accredit international rotations against. In this draft medical, surgical and emergency terms undertaken in Australia are defined as needing to being to '*approved accreditation standards'* – which currently do not exist for overseas placements in NSW. Issues surrounding adequacy of supervision, training and experience are compounded by other factors including allocation, welfare, registration, effect on vocational training (recognition of term by colleges), cost to the intern among others. Further outline and consultation regarding location and duration of placements is required.

Emergency Medical Care

Of all the aspects of the draft registration standard considered by NSW JMOs, the issue of Emergency Medicine training garnered the most reaction. The major areas of concern are summarised here along with other issues identified by the NSW JMO Forum.

Consensus across all JMO responses was that the core Emergency Medicine term was the most important term an intern undertook, regardless of career aspirations, and that substituting it for a GP placement would be a serious mistake.

Emergency is the one core term with significant and fundamental impact on the learning of intern. If this new standard is adopted there exists the possibility for interns to pass through a GP Emergency Medical Care rotation without having had:

- Adequate supervision in Emergency Medicine to assess their fitness in independent clinical practice
- Exposure to enough numbers of undifferentiated patients to recognise truly emergent presentations
- Sufficient experience in dealing with a variety of triage categories
- Enough time in the rotation to be adequately learn, engage and be assessed
- Understanding of the role of the emergency department and its relationships with other health providers within the hospital and the community.

These deficits would lead to significant impacts on the quality of the interns' knowledge and abilities, which would follow them through to further training.

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Emergency Department exposure is imperative in the process of creating quality practitioners – regardless of the field of final practice. Without adequate emergency experience Australia cannot produce physicians, surgeons, general practitioners, psychiatrists and of course critical care clinicians of the standard that the Australian public deserves.

Whilst understanding that the impetus for this change comes about from a deficit in emergency training positions both in NSW and with more significant shortfall in other states and appreciating that a national standard must encompass all - we have the following concerns:

Minimum standard
Setting a minimum standard does not encourage NSW training providers to continue to maintain their current high standard of emergency training. How will emergency training providers be supported in providing quality education and training if national standards would seem to provide rationale for 'lowering the bar'?

Accreditation
This draft refers to suitability of posts '*to be assessed against guidelines issued from time to time by the Board.*' In general, as the guidelines which are mentioned in the document are as yet unwritten there is no way to be sure what the standards will ultimately represent as much of the wording is not specific enough to enable accurate interpretation. Similarly the duration of timing between assessments of posts must be made more explicit. The JMO Forum expects that all supporting documentation should be made available for consultation

and feedback with the next iteration of the draft standard and must be written prior to finalisation of this standard.

The proposed standard seems to permit the possibility of non-standardisation of the emergency JMO experience - by allowing rotations within this essential core term to be so variable as to render the whole concept meaningless. Whilst assuming that the definition of '*general practice with exposure to emergency medicine'* will be made more explicit in supporting documentation we reiterate our concern that the capacity for misinterpretation/abuse of the standard is very real without clear delineation. The skills, supervision and training a JMO in the Emergency Department of a metropolitan tertiary referral trauma hospital will receive is magnitudes in difference from that of the JMO placed with a Rural GP servicing a 5 bed hospital, and yet under this draft they would both be designated as equivalent Emergency Medical Care terms.

Competency: The Trainee in Difficulty

The ED term is the one core rotation where the JMO has the greatest independence matched with the closest supervision and any potentially dangerous deficits in skills and knowledge are identified. This is a by-product of exposure to all of the elements mentioned below, some of which may be lacking in a GP Emergency Medical Care setting – casemix, supervision, speciality care, multidisciplinary teamwork. Struggling performance by JMOs is infrequently identified but Emergency Medicine is clearly the term in which this is most frequently brought to the attention of the trainee and the Director of Training (on review of >3,000 term assessment forms in NSW 2010).

Case Mix

Exposure to the "undifferentiated patient" across all triage categories, age groups and genders in "Emergency Medical Care" is extremely important in intern clinical training. The new standards may lead to the intern simply not gaining enough experience in recognising or managing common clinical scenarios. In a rural context it is more than likely that the patients will be known to the GP or intern and that rather than being undifferentiated, the encounter will merely be an extension of care in a different physical location.

Supervision

Rural GPs are not generally Fellows of the Australian College of Emergency Medicine (FACEM), and have different skill sets and approaches to the practice of emergency medical care. They may not be able to teach or supervise best practice standards depending on their focus of continued professional development, time constraints and the facilities at their disposal.

This is in contrast to Rural Hospital Emergency Departments, which are staffed by FACEM and the distinction should be made between these locations and small rural hospitals with Casualty departments staffed only by general practitioners.

Trainees in a Rural GP placement will likely only have one supervisor throughout the term. This restricts their exposure to senior emergency clinicians with different areas of expertise, quarantined teaching time with these people and the ability to learn and model from different senior staff.

Systems Knowledge
It is possible in the event of serious trauma or emergency the intern will participate in little beyond getting a patient ready for transport to another facility. The flow on from this lack of clinical exposure is the additional deficit in systems knowledge, speciality care and interprofessional and interdisciplinary care management vital to the Emergency Medicine perspective. Many GP-run Casualty Departments are unlikely to have in-house specialty medical/surgical services, occupational therapy, physiotherapy or Aged Care Assessment Teams.

Availability of Placements
In NSW there has not been, to the Forum's knowledge, a consensus or position paper from representative bodies of rurally based general practitioners acknowledging capacity for expansion as providers of Emergency Medical training to interns.

NSW Rural GPs already struggle to service their clinical population with large catchments areas and high provider to patient ratios. There are currently only small numbers of appropriate and accredited Rural GP placements in NSW – the numbers of those who currently provide an Emergency Medical component to their rotation is unknown - as is the quantity of GPs willing, able and accreditable to provide Emergency Medical Care training in the future.

At the last assessment of NSW participation in PGPPP there were less than 20 placements operating. PGPPP placements place significant administrative, financial and accreditation burdens on already overworked rural GPs who are participating in the program without the additional complexity of Emergency accreditation. There is no incentive to training hospitals to second interns to GP placements again through financial, administrative and rostering issues.

Equivalency
The issue of ambulatory care experience should be separately addressed when determining core terms for junior doctors. Whilst appreciating the importance to all junior doctors in understanding the role of the general practitioner in all geographical settings and that in the future location of training and practice will be expanded, using the Emergency Medicine term as a means to providing that experience is inappropriate.

Welfare
Poor outcomes in training and workforce retention may result from poor supervision and poor rotation structure. Rotations undertaken in community and lone supervisor environments can be highly stressful. This issue has already been identified as relevant in Rural GP rotations with a generalist only focus and would be amplified in the context of dealing with emergency situations with poor outcomes.

Extended Settings
The Summary paper attached to the proposed registration standard specifically references rural general practice settings however the standard itself refers only to general practice with exposure to emergency medicine. It is unclear whether this can be taken to mean the general practice could be only in a rural location or whether all general practitioners with emergency medical duties may be eligible.

The rationale for identifying GP placement with emergency medical care exposure as the only possibility for equivalent experience is not clear. There are other settings with Emergency Medical Care components which should be considered and investigated:

- Anaesthetic rotations
- High Dependency Units
- Medical Admission Units
- Emergency Retrieval Services

If unavoidable consideration should be given to specifying splitting of terms between Emergency Medicine placements and those with emergency medical care exposure such as those suggested above rather than opting for an either/or approach. This would ensure that at a bare minimum, some time would be spent in an appropriate Emergency Department setting rather than none at all and that a complementary experience would be gained throughout the entire term eg ED/MAU, ED/ Anaesthetics.

Restructuring of Term

There is room to change the construct of the intern Emergency Medicine rotation so that supervision and patient flow do not negatively impact on each other. Capacity exists to expand "physician's assistant" shifts within Emergency Departments. Pressures on metropolitan emergency departments could be addressed by redefining the intern ED experience to include a mixture of independent practice plus allocated times spent 'clerking' for senior staff. Many JMOs have found the experience of shadowing emergency physicians, watching them take histories, perform examinations and procedures, and acting as their assistants throughout the day. Replacing residents with interns does impact the working function of an Emergency Department and is not a safe or practical option, however restructuring the intern ED term would allow for greater capacity for intern supervision.

Level of Experience

The intern who has not had adequate Emergency Medicine exposure will be seriously compromised in their ability to function in a PGY2 level rotation with an emergency care component, including rural general practice. The JMO Forum does not endorse filling Emergency Medicine PGY2 positions with PGY1 trainees, but recommends that more senior doctors in training are suited to expanded settings rotations with less immediate supervision. Extended settings are necessary in the context of ongoing pressure to find training opportunities for doctors in training when they gain their unconditional registration. The intern who has had appropriate Emergency Medicine experience will be capable of functioning in Emergency Medical Care positions as a resident.

Conclusion

Having identified serious concerns with the emergency medical care and international placements proposed in the standards, the constraints of the current situation regarding internship placements in NSW are acknowledged.

The NSW JMO Forum welcomes the opportunity for further consultation with the Medical Board of Australia regarding intern registration standards. Questions and comments regarding the content of this document can be forwarded to jmoforum@ceti.nsw.gov.au.

APPENDIX : SAMPLE OF COLLATED AND DEIDENTIFIED NSW JMO RESPONSES TO PROPOSED CHANGES TO INTERN EMERGENCY MEDICINE ROTATIONS

RELEVANCY TO ALL SPECIALTIES

'Allowing an emergency medical care term instead of an emergency medicine term: I think an emergency medicine term is a core component of medical training, because the ED is the front line of the hospital and an understanding of how it works is fundamental to every other hospital-based position.'

' Every speciality has an association with ED - whether the intern wishes to train in paeds, physicians, surgical, o&G, psych, GP or critical care they will have a relationship with ED. I think that every doctor should have at least 1 hospital based ED term - so that they can draw on their experience in their future practice as well as have a good understanding of the role of ED in their specialty.'

'I am a surgical registrar and I have some issues with the proposal that interns don't need to do an ED term. ED is the only important term for interns to undertake. Surgical terms are useful for future surgical trainees and medical terms are useful for budding physicians, however ED is the only term that exposes interns to all facets of medicine. Understanding how ED works is vital to understanding the health system and is especially important for future GPs, particularly in rural areas, who will refer their sick/complicated patients to hospital.'

'However it is also important to understand emergency medicine if one plans to work in the community (e.g. as a GP), and a GP-based 'emergency care term' would not be as valuable: The emergency department frequently receives referrals from general practitioners (and vice versa), and an understanding of what can and can't be done by an emergency department team, what conditions need assessment in hospital and what conditions need admission is important for GPs to understand.'

'Referrals from GPs need an understanding of what can and can't be done by an ED team / what needs hospital assessment / what conditions need admission'

'Important to understand how an Emergency Department works if you plan to be a GP, therefore a GP based term is not as valuable'

APPROPRIATE LEVEL OF EXPERIENCE

'I think as a PGY3 that would be a good experience, but as an PGY2 and definitely as an intern you need the support and formal framework of a hospital to do ED.'

'A suggestion would be to make it an RMO only secondment term, and to spare interns the trauma of being foisted on rural hospitals which try, but often fail to provide adequate supervision to JMOs due to limited resourcing'

'I would oppose putting interns in rural GP locations for the same reasons that interns should not work frequently in fast track or paeds. They do not know the important protocols well enough or have the ability to recognise red flags. On the other hand, I have no problems

with residents being placed with rural GPs and think the independence may make a good experience and stepping stone to further rural GP work.'

'I am doing a **** GP term at the end of this year - This involves some ED on call and also some GP surgery time. I am so glad that I have done 2 ED terms at **** Hospital prior to being placed as an RMO in a small rural ED. I think it would be unfair to place interns in this situations without prior hospital ED experience as has been suggested.'

' If the rural GPs were carefully selected I think these could be good rotations. In smaller country towns there is still a lot of hospital exposure through GP practices as they staff the hospitals too and have great skills to pass on to junior staff in managing acute issues with minimal resources. However, I think increasingly these GPs are becoming more rare, which would make the sourcing of enough to fufill the program difficult, and runs the risk of junior doctors being left with less senior supervision and decreased experience and case variety as you highlighted in your e-mail. I wonder would rotations such as these be better suited to residents not interns'

EQUIVALENCY
'Having done both an ED term and a rural GP term, I can say, at least from my experience, they are nothing alike. If my experience is anything representative, it would be a grave mistake to substitute one for the other, except perhaps in the case of truly rural GPs practicing remotely. The case mixes are different, and the urgency is different as well.'

'spending time with a rural GP is worthwhile but does not replace an Emergency Department'

'Spending time with rural GPs would be really worthwhile for a number of reasons, but it does not replace the need for a hospital based rotation.'

'I think it would be beneficial to make one term of general practice a compulsory/more widely available term for internship (in addition to, but not a substitute for emergency medicine). This would not only provide interns with an important understanding of general practice (helping to better understand the relationship between the hospital and general practice system and hence optimising their ability to write appropriate discharge summaries) but would also create additional training posts, freeing up more available hospital training positions.'

'offer GP as a rotation but it is not an adequate substitute for an ED placement'

'I believe the training and exposure in the ED is invaluable. I think the Emergency Medical Care rotation with rural GPs still has the potential to be an interesting and useful rotation, but there is a very high probability that it will be largely a GP term only. Therefore, while I think it should be offered as a rotation (one that I would happily do myself), I do not think it is an adequate substitute for an ED placement.'

'The rural GP rotation should be considered as an option in addition to an ED term, especially for people who have completed more than one ED term per year (I know many colleagues who have had 2 ED rotations in a year at *** and *** hospital).'

'I think that there is a role for GP terms that have some ED experience but they should not replace hospital ED terms. They should continue to be considered GP terms (PGPPP) and not critical care terms.'

'Although I do not feel that the experience with a rural GP is comparable to a hospital Emergency term for reasons that you are aware of, I think the best way to go about it would be to offer it as an option. There will undoubtedly be doctors who know that they want to train as GPs who will opt for the rural GP experience and they will of course derive benefit from it. But it is unknown how many people will choose this and therefore I think you will need to have a trial year. Of course, giving an "option" may prove to be difficult if not many people choose it and your are then forced to assign rural GP positions to people who dont necessarily want it. But I think, somehow you will need to have a trial year, to gauge the response.'

'A far more sensible approach would be that ALL interns must do an EDterm and that those who have already chosen to become GPs should beallowed to leave the public hospital system after completion of thisterm to complete the remainder of their intern year at GP practices. Ifthey are not intending to work in the hospital system there time is far better spent actually learning from their future peers in general practice rather than wasting time in the beauracracy of public hospitals.'

'My concerns with the GP ED rotation is probably obviously the lack of hospital ED experience, and forcing more people to potentially do rotations that will not be useful ,ie country GP rotations and country GP ED rotations. I think it's great for those who want to do that as a career but with more and more GP based training it may force people who wont specifically benefit from this kind of training to have to undertake it. '

EXPANDED SETTINGS/SPLIT TERMS

'is it possible to split terms to spend half in each so you don't miss the learning opportunities an ED has to offer'

'If there was a GP type unit (similar to MAU, but for non hospital worthy cases) adjacent to the E.D in a tertiary hospital staffed by junior doctors, this may relieve the burden of non acute presentations to E.D, and yet still allow interns to have some time in both to increase the breadth of experience.'

' If ED placements are limited, I think it might be more beneficial ifan intern is allowed time to spent half the term at a rural GP andhalf the term at an ED in a hospital (ie 2 pplswapping for the ED-rural GP position within a term) to try and minimise pitfalls in relation to casemix, skills, supervision and exposure to theundifferentiated patient,etc'

'A hospital based rotation is obviously seen as important as it is a compulsory term for JMOs. Keeping in mind the shortage of supervisors and abundance of JMOs, perhaps shortening the hospital based emergency term is a compromise (although this is not ideal either).'

'I have some concerns about possibly expanding the emergency term to include rural GPs with an emergency focus (primarily related to patient load and variety), but understand the need to find extra rotations. If this does come in, maybe it could be split with emergency

terms, so interns spend half their time in each, therefore do not entirely miss the learning opportunities an emergency department has to offer?'

'No, I think these proposed changes are ridiculous - even given the ridiculous number of grads in the next few years... what lack of foresight! If the term is going to be softened so much, then it is not a valuable learning experience... and is therefore a waste of time. To be a good doctor we need this ED experience to stay much the same. Why not use the smaller peripheral hospital EDs more? I have had some great learning experiences in them.'

MINIMUM TIME
'In terms of length if time spent in ED... I think we currently do the minimum required to feel comfortable and confident in a variety of different situations and understand what's expected of us.'

'I think 8 weeks of ED is adequate exposure - I learnt most things by the 8 weeks.'

'In regards to the proposed 8 week term, I feel that 8 weeks is too short and in my experience it takes at least 6 weeks to get to know a department and it is only in the last few weeks that you really start to become proficient and optimise learning.'

EXPERIENCE/CASEMIX/EDUCATION /SUPERVISION
'Some days in a small, rural ED hardly any patients will present to ED…rarely see a true emergency….in contrast a metropolitan ED term is the best learning experience'

'If your only ED exposure was smaller peripheral hospitals then the learning opportunities are far less beneficial.'

'The scrapping of emergency term in favour of rural GP would be a mistake. From my experience having done a rural GP term as a student, rural GP does not even closely reflect the experience in a busy ED. The practice I was in in ***** had neither the acuity of cases nor the appropriate level and competence of supervisors to provide the kind of training I experienced this year at POW.It would be a pity for both new doctors and the health system if future interns were deprived of the ED learning experience.'

'Emergency Medicine - this is an outrageous suggestion which is only a quick fix to the problem that should never have happened in the first place. I have applied for GP training this yr, so Im not saying this from an "I hate GP" perspective at all. But there is a reason that ED is a compulsory rotation. Many rural GPs have a lot of ED experience and see a variety of cases. And yes, a lot of ED in big cities is in fact GP work. But in terms of facilities, staff, expertise and supervision it is inappropriate to equate the 2.

'I honestly think that there is no possible way a GP rotation could provide the expertise or required skill sets for an ED rotation. I think that would be a huge mistake.'

' a full term in ED is necessary as an intern'

'By far the most important training of the entire year'

'Learn as much from doing an ED term as you do for all the other terms put together'

'I agree that placements with GPs would not give you adequate exposure to a variety of patients. It would also limit your exposure to those who are critically ill that present to the ED.'

'For me my ED term was essential to learn basic hospital management for a wide range of clinical scenarios. It also exposed me to acute medicine which, as an intern, you often don't come across as you are often doing discharges or medication charts!!

'I don't see how inclusion of even smaller, peripheral GP-run emergency departments could be safe or of high yield to JMOs. The GP-run departments often do not have a GP on site, and the GP is only called a few times a day. The patient flow is often low acuity and I don't believe their is adequate exposure to good emergency medicine'

'In terms of the ED placements it is extremely important to ensure that the junior medical staff especially interns will be adequately supervised in these locations. My greatest concern is that they will miss out on a crucial learning term as an intern. Often the emergency department term is the only term where interns have the opportunity to see, diagnose and manage patients whilst being observed by seniors rather than simply completing much needed paperwork. It is a place where if supervised correctly there is great learning potential and i would be concerned that this will not be the case in smaller peripheral hospitals/GP clinics.'

'Having graduated from University of *** where I undertook several rural GP placements, there are many reasons why I would disagree with internship rotations with rural GPs. These rural GPs are often overworked and the degree of supervision they may be able to provide for interns is constrained by time and workload. At some GP practices, there was only one GP who was on-call 24/7 and although these are places where you would get emergency medicine exposure, the GP did not even have time to talk to the medical student let alone provide adequate education and supervision for an intern. It would be unfair to increase the workload of the rural GP and expect them to supervise and educate a new intern. Even where GP practices are linked to a local district hospital, the hospitals are run by nurses with GPs having admitting rights and spending most of the day in their practices. The medicine there involves stabilising the patient and transferring them to a secondary/ tertiary centre. I feel this would be very poor exposure to emergency medicine as these GP are not trained in emergency medicine per se (and the evidence base that surrounds this), case mix is limited and follow up to learn about management would be limited as patients are promptly transferred. Even during my emergency term at a hospital with many CMOs and 1 Staff Specialist on duty at all times, there were many times where I would be advocating for someone senior to review the patient that I had just worked-up, meanwhile stressing that my patient might be going downhill. '

'Rural emergency does not carry the same number of cases – you would not see the variety of medical conditions'

'I strongly feel that an ED term being replaced by a rural GP/rural ED would be extremely detrimental to the new lots of JMO's coming after us. I have just completed an ED term at **** Base Hospital and think it was/will be the best learning experience that I can possibly

receive throughout my internship! In contrast to this, I completed a one year placement as a final year medical student with a rural GP in a similar region, which also included some time in the nearby hospital's small rural ED, and can safely say it was far less beneficial. Some days hardly any patients will present to the ED, leaving you sitting around with nothing to do, and rarely would there be a true emergency presenting to the hospital. Most semi-urgent cases would be bypassed to the larger hospital's such as *****. Being part of a larger ED at *BH there was constant exposure to major emergencies, trauma's, access to specialist's and great opportunities for practicing skills on a daily basis'.

'I guess it would depend on the ED to which you were exposed to - in my region for example if you were attached to a GP who also worked at **** Base a few days a week then this could potentially work well. However if your only ED exposure during internship was smaller peripheral hospital's then I feel learning opportunities would be far less beneficial.'

' It is my opinion that a rural GP term would not be anywhere near adequate to cover the area of emergency medicine which I believe to be crucial to the JMO training. This is one of the few terms when we are expected to work relatively independently as "real" doctors as opposed to secretaries to wide range of undifferentiated patients. Unfortunately, GP's often do not address these problems and will refer quite quickly to hospitals as well as I would assume the majority of their patients are not undifferentiated but are presenting for chronic problems.'

'Experience is the best way to learn. As a result, I think the emergency rotation is important. There are a tremendous number of skills to be learnt in a busy emergency department. Rural emergency medicine does not carry the same number of cases. I would be concerned that interns undertaking this mode of training would not see the variety of medical conditions.'

'I think at least one term of working in the emergency department is essential for JMO training. That's where I had the steepest learning curve as an intern. I've done a rural GP term as a student and I don't think I would have gained this many skills if my ED term was replaced by a rural GP term.'

'In my limited experience, ED is a rotation where you quickly learn how buoyant you are in dealing with acute medicine. If you're supervised, yourself and the patients will keep your head above water, but if you're on a rough rotation, you sink fast, and repeatedly.'

'The level of supervision is highly variable, and though it is possible that there will be an increase in supervision with the introduction of an "emergency medical care" term, it is more likely that there will be the initial teething issues of non-homogenous aims, supervision and ability to deliver supervision and clinical support to JMOs. The spectrum of JMO experience will be even broader.'

'ED is a double edge sword, i'm not sure if i like it or not, but i definitely see the value in doing the rotation (in spite of any distress it may cause), but cos the individual (not to mention the intercollegiate, inter-cohort and inter-institutional) experience is so tremendously varied, making changes to it could introduce more cracks that JMO's slip

through, and we might not become aware of it for some time after the introduction of the change.'

'I think that all interns should have to do a rotation in the emergency department, and I don't think that this medicine can be taught in general practice for several reasons.
1. While a lot of cases seen in the emergency department are GP cases, actual emergency cases are also seen - trauma, MVA, anaphylaxis etc. which interns would not get exposure to in GP land
2. The emergency department provides a generally supported learning environment where interns get exposure to a wide variety of cases (and I think that one really does need to do a whole term to get exposure to less common scenarios). It's supported because there are senior doctors on hand at all times and also because you have access to immediate investigations. It's the one rotation where you get to work a patient up and see what happens'

'In regards to the Emergency medical care term being completed in the GP setting, I do not think this would be appropriate. I think that it is crucial that interns receive experience in a hospital emergency setting as this varies significantly from a GP clinic.'

'I am drawing on my experience in ED at **** as an intern and resident as well as my experience with a rural GP seeing ED patients (4 week student placement in **** - pop 2,0000, 2 GPs who run the 2 bed ED, small hospital and attached nursing home).I think that rural GP placements should not replace emergency medicine placements.
1. There are significantly less patient presentations to the rural GP ED which leads to significantly less experience in critical care
2. There is less equipment and services available in rural GP setting - for example there may not be a slit-lamp so this skill would not be built on, there may only be xray imaging, there are no specialist services to refer to and learn from
3. I think that it is important for interns to have a good concept of how ED works within the hospital system. To see and experience bed block from the ED perspective rather than just through receiving pages that say "look at all possible discharges".
4. Interns working in rural GP EDs would have a small number of senior doctors as supervisors, the individual supervisors may be very good doctors and teachers but they are not ED trained (not FACEM) and therefore would not be expected to have the same emergency medicine knowledge and experience or be as up to date with the evidence base as a FACEM accredited ED doctor'

'I valued my time in rural GP ED but it cannot replace hospital ED time. '

'Some rural GPs do a significant amount of ED medicine in peripheralhospitals. They see plenty of subacute and acute presentations and thiskind of exposure would be good for JMOs. It will expose them to adifferent kind of Emergency medicine though. The acute patients gettransferred to base hospitals like Wagga, Dubbo, Orange etc... The JMO will miss out on the management and diagnosis of theses patients inthat they may not have access to imaging, surgical/medical registrarreview and discussion as well as intubation etc... So their educationwill be more limited to initial assessment only of sick patients. This could be a problem. You'll still see full management of subacutepatients though.

'It sounds like a reasonable idea; rural ED experience could be great in providing a more general experience of ED but my biggest concerns are re: supervision. Supervision at a rural hospital; my experience of rural hospitals in general has been appalling in terms of close supervision of JMOs which is required soon after graduation. Need for adequate training of supervisors; teaching hospitals have years & years of experience about how to supervise JMOs; some smaller rural facilities are largely run by career CMOs/locums who often have little motivation/interest in teaching; thought needed on training up and how to accredit facilities/supervisors to take on JMOs.

'I have worked in all three settings (Tertiary and District Hospitals in ***, Rural Referral Hospitals in *** (Large) and *** (Small)) and I do not believe that this change would benefit trainees. It would probably further stretch rural services i.e. very busy rural GPs. As you point out there would be a high risk of inadequate supervision for the JMO involved (if placed in a small rural setting eg with a GP also running their own practice) and therefore the high risk of poorer outcomes for patients, surely patient care should be the first concern? Also the educational value of the term comes in to question. Whilst CMO's/GP's who run rural ED's are often competent, dedicated, caring doctors they often lack the approach/evidence base that a FACEM will have and thus teaching and guidance around topics is of a different standard'

'Even though I do not want to pursue a career in emergency medicine, I greatly valued my terms there. It was in the ED that I learnt to be a doctor. I gained much needed clinical skills and it taught me about the administrative/ logistical requirements of getting a patient admitted into hospital. It would be quite dangerous if the only timean intern examines patients/ requires their own clinical skills is on overtime/ ward cover shifts when required to assess a patient with chest pain/ shortness of breath and no one around to supervise them or give them feedback. As an intern in the emergency department ,registrars were required to review all of my patients (although the degree to which they "reviewed" my patients was variable), but regardless I gained feedback on my clinical skills. When you independently assess patients and these patients are then reviewed bya registrar, your weaknesses become apparent. I read up on conditions I didn't fully understand and sought practice on examinations I felt I wasn't good at. I learnt from my mistakes. But I also learnt from my accurate assessments and gained confidence in my own abilities. When you start out you can feel like you are teaching yourself clinical skills and you just need someone to tell you you are doing well. With a touch of confidence you stop second guessing yourself and become a lot more efficient. I also gained something from feeling that by doing your job well you have actually impacted on the patient's health and done a service for the department. As a doctor you should know how to perform basic life support and have experience in resuscitation. However the emergency department is more than a resuscitation/casualty treatment area it is also the main entrance for admission into hospital. Therefore I feel that anyone who intends to work in a hospital should understand how the department functions.'

'My experience of rural emergency departments staffed by GPs is that they function a lot like an after hours GP practice. They do see some acute medicine, but rarely.'

'However, I do not believe that a general practice term (in any form)can replace an emergency medicine term.'

'Yet certainly against the Emergency Medical Care idea - a full term in ED is necessary as an intern. By far the most important training of the entire year. I think you can almost learn as much doing your ED term as you do for all the other terms put together!'

'I don't like the idea of a rural GP term with ED exposure completely replacing an ED term for some people. These people will get a good experience with a rural GP, but will miss out totally on the variety of presentations and ED experience that you can only have in an ED.'

'Emergency medicine in a city/large rural hospital does not equal small hospital rural emergency medicine.'