From: Barrington, Dianne (Health)
To: medboardconsultation
Subject: Submission
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Thank you for accepting my submission.

If smaller jurisdictions are to train enough medical graduates to meet and maintain their needs, then the current model of JMO training will have to be revised. In particular I refer to maintaining numbers of rural general practitioners. To foster careers in rural general practice, graduates need opportunities to experience rural general practice, yet this is disproportionately available in smaller jurisdictions.

In rural South Australia, the geography and population density mitigates against 'metro tertiary look' institutions with largish numbers of resident specialists on site. Given this, the proposed standard for intern training immediately discriminates against the average country hospital (in SA) as a teaching site for junior medical officers (and interns in particular) and restricts opportunities for 'rural exposure'. No 'specialist' supervisors and no 'blocks' of training = no internship.

The hospitals concerned are run by general practitioners who don't manage patients in 10 week blocks of medicine or surgery, but who provide general medical, obstetric, anaesthetic, first responder emergency and other services across a 24 hour period as demanded by who walks through their practice door.

When the Flinders University introduced the Parallel Rural Clinical Curriculum (PRCC) to its year 3 students, it received its fair share of criticism from outside. Not only has it proven to be highly successful, but year 3 medical students are queuing up to apply for 12 months clinical experience in a rural location, supervised by rural general practitioners and working to a defined curriculum. The PRCC curriculum model has been adopted by other countries and is proving just as successful.

Could an internship be conducted thus? The National Junior Doctor Curriculum could provide the framework to support the experience. JMOs would see aspects of practice medicine as well as hospital medicine. I would expect the range of skills experienced to exceed those in a metropolitan location, given that many rural GPs also provide obstetric, anaesthetic and general surgery services. Where VMOs are on site, there are opportunities to gain specialist educational input. Where a general practice registrar is on site, there will be opportunities for interaction at another level. There are greater opportunities to work in inter-disciplinary teams and learn from colleagues in other disciplines, because that rigid medical hierarchy of the tertiary centre does not exist. General practitioners are experienced teachers, often supervising year 1 medical students through to general practice registrars.

I note that many initial comments about the proposed AHPRA standard for intern training have argued that the standard of intern training must not be allowed to slip when offering 'flexible alternatives'. Given the success of the PRCC, it would be hard to argue that there would be a drop in the overall standard of intern training if it was conducted in a rural location and supervised in rural general practice.

Some students identify early as potential rural practitioners. Some hold rural bonded scholarships. Smaller jurisdictions need to be able to provide opportunities for these individuals to progress their training in rural locations, especially at the intern and PGY2 level.

I understand that this suggestion will turn the intern training standard on its head; will require rethinking what will be accepted by medical boards for full registration; will require rethinking by the AMC and CPMC about accreditation standards for hospitals for intern training. To me it is obvious that the current model of intern training is biased towards metropolitan specialist training. Rural general practice needs equal consideration.

Dr Dianne Barrington