

ORIGINAL RESEARCH

Rural intern training

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ABSTRACT

In recent times, legislative initiatives in Australia have changed the method by which doctors enter General Practice. One result of this tightening has been to restrict the access of junior doctors to medical experiences outside the hospital environment, and force a closer examination of the 'generalist training' provided to junior doctors.

The Australian Medical Training Review Panel, created as part of these legislative changes, developed a series of recommendations about general training in 1996, one of which was to provide for rural and community experiences for junior doctors.

This article describes the experience of a 'Rural Intern' rotation from Flinders Medical Centre to the rural community of Jamestown, in South Australia.

Introduction

Obtaining the correct balance between service and training for junior doctors in their prevocational years has long been the subject of discussion in Australia and overseas¹⁻³. This debate has been hardened in Australia by the introduction of Commonwealth Government legislation in 1996 which

formalized General Practice training, and restricted the access of junior doctors to a 'Provider Number', the only mechanism for obtaining Government rebates for patient treatment through Medicare, Australia's universal health insurance system.

Concomitantly, the Medical Training Review Panel (MTRP) was formed. This panel is tasked with monitoring training



positions in Australia and addressing the concerns of junior doctors with regard to accessing training places. In 1996 it developed recommendations designed to guide those responsible for the training of junior doctors. One of the most challenging of these was that 'all postgraduate medical officer training include at least one rural term, be it in a hospital or general practice setting, and at least one community based term, again either in general practice or a community health service'⁴. This recommendation has been met by many in both administrative and clinical medicine with the attitude that it is just impossible to achieve, particularly for interns, who are yet to be fully registered and so cannot draw on Medicare rebates for their services. Since 1997, however, the General Practitioners of the rural communities of Cleve and then Jamestown, in association with the Flinders Medical Centre, have successfully maintained a 'Rural Intern' rotation.

Background

In 1997 the South Australian rural community of Cleve, through its resident General Practitioners, developed a proposal to train Interns in a rural community environment. Supported by the Commonwealth Department of Health and Aged Care and the South Australian Department of Human Services, eight interns rotated from Flinders Medical Centre to Cleve through 1997 and 1998 working under the supervision of the local General Practitioner. Professor John Murtagh, Professor of General Practice at Monash University (retired), positively evaluated this pilot program and recommended that it be allowed to continue. In 1999 the position was transferred to Jamestown in the mid-north of South Australia where two interns undertook ten-week rotations, once again under the supervision of the local general practitioners.

Flinders Medical Centre is a large tertiary referral centre in Adelaide, South Australia's capital city (pop. 1million). It is the major teaching hospital for the Flinders University School of Medicine. Cleve is a town of 1000 people 600km from Adelaide. This farming community has one resident

doctor servicing a hospital and community health center for a population of 2000.

Jamestown is located 250km from Adelaide and has a population of 1500 people, with a further 1000 people in the region. Like many rural South Australian towns, the hospital has 20 acute beds and an attached aged care facility able to manage 15 people. Two full time General Practitioners provide services to both the hospital and a purpose built Community Health Centre. The dominant industry in the region is cropping of wheat and barley.

Methods

To explore the impact of this program in 1999, semi-structured interviews were undertaken by the Medical Education Officer at Flinders Medical Centre with the Interns, supervising General Practitioners and Jamestown Hospital Administration. The interviews were transcribed and analysed for emerging themes by two of the authors. The participants were given opportunities to make comments on the validity of the draft analysis, and these comments incorporated into subsequent revisions.

Interview Summaries

Interns

Both Interns gave very positive and similar responses when questioned about their work experience in Jamestown.

Both junior doctors raised the issue of autonomy in clinical decision making. Large urban teaching hospital terms offered 'almost no autonomy', placed interns at the 'bottom of the food chain' and perpetuated the concept of a junior doctor as a 'gofer' of information. In the community setting, however, they described an increased sense of autonomy in clinical decision making and in particular felt they had the opportunity to develop and implement patient management plans. The closest comparative urban hospital term was Accident and Emergency where there was a similar degree of clinical freedom but not the same opportunity for patient



follow up. The rural community experience allowed the interns to 'see the patient, admit them and then continue to see them on the ward'.

The variety of patients seen in the rural context was viewed positively by the Interns. They felt that they had experienced a greater spectrum of patient presentations as opposed to the largely acutely ill patients admitted to the teaching hospital. Access to outpatients in the context of the teaching hospital was limited whereas in the community they had the benefit of both inpatient and outpatient work.

The reasoning behind choosing a rural term was attributable in both cases to a perception that they needed to be 'strategic' in approaching entry into general practice. Equally they felt the need to 'cement' the notion of a career choice in rural general practice and fulfill a desire to experience a greater breadth of clinical experience than was available in teaching hospitals.

Time spent in the rural community was acknowledged to provide benefit to the doctors in a variety of ways. The Interns felt that this term enhanced practical consulting and history taking skills, as well as procedural work. This improvement related to having more time available to talk with patients and the ability to provide follow up. Continuity of care from the surgery, through to the hospital and then home was a prominent feature in both interns description of their term. The supervision from the General Practitioners was described as 'close' and there was more feedback on performance than would routinely be available at a large teaching hospital. In the area of prescribing the interns suggested that there was more 'realism' to drug regimens, there was less of an 'obsession with new and fancy drug treatments' and that the prescribing experience in the rural context was good compared with the large hospital. The supervising General Practitioner checked each prescription they wrote. Equally, decision making in ordering tests for patients required closer thought. Reflection of how a test result would influence management became more important as factors such as distance and travel for a patient was taken into account.

Working hours for the Interns were similar in the rural and teaching hospital terms (averaging 100 hours per fortnight), but both Interns felt that the work was less tiring in the rural term. Possible reasons advanced for this perception were that the work was more varied and interesting, and that their time management and prioritizing skills were better developed by the rural term experience.

One Intern felt that there was a marginal gain in overall professional confidence as a result of the rural term, whilst the other felt that the major increment in self-assurance had occurred in the early weeks of the intern year.

General Practitioner Supervisors

The presence of an Intern kept both doctors 'on their toes'. They described as 'stimulating' the need to articulate and justify a particular approach to patient management. Both GPs said that they enjoyed teaching and in particular seeing the improvement of an intern and their performance over the period of the term. The flow of information was seen as a two way process with the junior doctors introducing new ideas and practices as well as researching new and appropriate information.

There was a sense that workload and working hours in the presence of the intern were increased and that this increase was due to supervision and teaching. Fee for service income was compromised with the intern working after hours, as all those patients would normally be seen by the duty general practitioner and an invoice raised. On balance, however, the General Practitioners felt this was compensated for by not having to be first 'on call', and the presence of a separate block remuneration ('teaching supplement') based on that of the Royal Australian College of General Practitioners.

Hospital Services

Within the hospital environment there was acceptance and appreciation of the work performed by the Intern. The Chief Executive Officer reported that there was positive feedback from the hospital workforce as the Intern had more time to



explain conditions to patients and discuss issues with the health care team such as underlying pathology and pathophysiology. He felt that routine documentation was more up to date with the intern present than was usually the case with the busy general practitioners. There had been a slight increase in theatre time associated with teaching of the Intern, but this was probably balanced by a reduction in some fee for service activities. He also said that there had been no complaints from patients about the Intern, and in general the community was very supportive of the presence of the Intern.

Overall he had been very pleased with the program and was of the opinion that it should continue.

Discussion

The pre-registration Intern year was introduced to provide junior doctors with a period of well-supervised learning prior to entering unsupervised medical practice. The perception at the time was that hospitals offered the most closely monitored medical environment to provide this with on site resident staff support. Although only small numbers of Interns have participated in the Jamestown Intern program, the authors feel that the quality of the experience alongside the close supervision provided by the GP supervisors requires recognition and will be further reported as more junior doctors complete the program.

In maintaining an Intern position that is based in the community the supervisors of the program have faced and responded to many questions. 'Who is supervising these interns?' 'How can this work when they cannot even write prescriptions?' 'It must be very hard work for the supervising General Practitioners. How do they find the time?' 'Yes that's all very well, but are they actually learning medicine?'

The qualitative evaluation undertaken through 1997 and 1998, as well as the interviews detailed above, certainly suggest that positions such as these are sustainable for the 'host' practice and valuable to the junior doctors. In South

Australia, while medical students have the opportunity to gain experience in rural communities⁵, it has not been common to rotate resident staff to regional areas in any capacity. Innovative resident positions that recognize the central role of rural General Practitioners in both hospital and community practice may well represent the means of responding to initiatives such as the MTRP. Equally, it provides the important 'vertical integration step' for new graduates leaving medical courses that are now containing increasing amounts of rural experiences.

One unexpected consequence of the excellent outcome of the rural term based in general practice has been to promote debate about the value of many time honored training positions within the busy city hospitals. It is clear these hospitals face increasing pressure on duration of stay, bed numbers and acceptable working hours for doctors in training, issues that strike at the heart of their central role in general training^{6,7}. The reform of junior doctor work practices, either through the modification of existing placements or the creation of new positions, which enable junior doctors to track patients back to the community in association with primary health care providers, must represent a new way of approaching training.

The development of the rural term and interview assessment process strongly suggests that the interns experience a well-supervised and varied term. The evolution of the evaluation, however, must move toward a quantitative process that links the experience to financial and opportunity costs, and ultimately an assessment of cost benefit.

The Rural Intern rotation to Jamestown has been able to overcome the barriers of provider number allocation, outside prescription writing, Medical Board accreditation for intern training and concerns about supervision to provide a unique pre-registration experience for junior medical staff.

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