However, community-based education should not come cheaply. Many general practitioners have been hosting students in their practices for years, and are motivated to do so because of an interest in education and the stimulus provided by students in keeping up-to-date.[4] Rarely are they solely involved because of remuneration. While there are payments for teaching, these do not reflect the time and loss of earnings that GPs incur in providing attachments.

If GPs are to be asked to be more involved in the undergraduate curriculum, there should be a true costing of the process. GPs who teach students are often involved in vocational training of GP registrars and, from this year, in supervising interns in general practice through the PGPPP (prevocational GP placement program). I am concerned that we are approaching full capacity, and that finding quality GP placements for all these students and junior doctors will become very difficult. One solution for practices that provide a substantial amount of training would be to pay them enough to employ an extra doctor either to carry the teaching load or free up others to do so. However, even if there was the funding for this, at present, there is a shortage of GPs to provide patient care, let alone education.

There certainly needs to be a rethink in relation to the prestige given to clinicians who teach, adequate training in education for clinical tutors, and the necessary resources to provide good learning experiences. Not only do I believe that all medical students should have the opportunity to work and learn within general practice, but that all junior doctors should have at least one attachment in the community. GPs will need support, training and space to offer this, and we should not continue to rely on their altruism to support medical training.

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Registrars cannot provide full teaching for juniors

Kenneth Wong

To the Editor: I was recently amazed to learn that the solution to the educational needs of prevocational doctors was more teaching from registrars.[1] My understanding was that registrars were themselves in a predominantly learning position, desperately hoping to glean some scraps of wisdom from consultant doctors. Often, the registrar, this supposed demi-god of all knowledge, is only 1 or 2 years ahead of the prevocational doctor and permanently juggling yet another postgraduate examination and the rigours of clinical duties. Then, with Australian medical schools springing up here and there, there are the inevitable hordes of medical students. So, registrars have an inherent and significant conflict of interest, namely, self-education to be able to continue climbing the slippery slope of postgraduate vocational education versus the altruistic provision of education for others.

Perhaps graduating medical students need to take personal responsibility for their own education. Continuing medical education (CME) is a lifelong process that requires individual initiative. Support from the various specialist Colleges is welcome but not essential. Weaning prevocational doctors from their dependency on "formal education" is an essential first step towards independent clinical practice. This is not to say that CME for prevocational doctors should not be supported, but rather that it is unrealistic to demand that it should all be spoon-fed from registrars. An informal verbal survey of my registrar colleagues unanimously showed that we would all like to expand our teaching load, but not at the expense of clinical care.

So what can the system do to support the beginners? Nurses have clinical nurse educators, and soldiers have drill sergeants. The nursing education system and the army have both recognised the value of employing personnel purely for educational purposes. The medical profession could do likewise.

The pretence that service is educational for prevocational doctors should be denounced. Routine tasks performed by prevocational doctors that do not require medical expertise, but consume much time, could perhaps be delegated to non-medical professionals. This would free up time for medical education on the job. However, protected time for teaching by adequately remunerated clinical teachers requires workforce expansion and, ultimately, public funding and political will.

Finally, from within a profession that often subscribes to the view that good resident staff are seen but not heard (that is, work hard and don't complain), recognition by consultants that they too were once beginners may lead to positive cultural changes.

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Rural internship for final-year medical students

Tarun Sen Gupta and Richard B Murray

To the Editor: Recent reports have highlighted problems with our capacity to teach medical students.[1,2] Others have described workforce problems, calling for innovative approaches.[3] The Rural Internship program at the James Cook University (JCU) School of Medicine may contribute to such strategies.

The first regionally based medical program in Australia, the School was founded in 2000 and has recently graduated its first cohort.[4] All final-year students undertake an 8-week rural internship, having previously completed 12 weeks of structured rural placements in their 2nd and 4th years, and a core 2nd-year subject — Rural, Remote, Indigenous and Tropical Health.

The rural internship allows students to develop and practise clinical skills in a rural context. All students in the first cohort completed the rotation in 2005 in hospitals across northern Queensland, usually in groups of two or three, providing full-time inpatient, outpatient and after-hours duties under supervision. Hospitals were in rural and remote communities (Rural, Remote and Metropolitan Area classifications 4–7; comprising rural areas with populations < 24 999 to remote areas with populations < 5000), with demonstrated capacity to supervise and teach. Most were 2–4-doctor hospitals, although one larger hospital (Mt Isa, 35 doctors) and one smaller hospital (Moranbah, one

doctor) were used. Supervision was provided by experienced rural doctors (medical superintendents and senior medical officers) holding an FACRRM or equivalent.

Evaluation in the first year included student questionnaires, site visits, interviews and follow-up teleconferences with instructors. Early evaluation suggests that the rural internship provides senior students with valuable experience in the health care team. Students accept limited responsibility and further their abilities and confidence to undertake the role of the intern. Importantly, specific feedback from medical superintendents indicated that the rural interns made a net contribution to the system when teaching time and supervision were considered. The rotation appears to meet educational objectives without burdening (indeed, possibly bolstering) the local workforce. This is consistent with other reports of students undertaking extended rural experiences.[5] It also addresses a common conundrum: rural instructors and communities are keen to teach students and appreciate the long-term workforce implications, but are constrained by resources, particularly time.

This model extends and enhances apprenticeship-style medical education through its rural focus, distributed delivery and involvement of the entire cohort of students. The contribution to patient care by senior students and junior doctors creates a consultant–registrar–resident model, in which experienced rural doctors function as consultants providing advice, support and tuition rather than predominantly face-to-face patient care. We feel that this innovative approach should be explored in other settings.

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Lessons to be learnt from general practice training

William Coote

To the Editor: Three recent articles discuss Australia's medical education arrangements,[1-3] but do not propose a way forward.

Dahlenburg notes "at least 10 different agencies are involved in postgraduate training", leading to a "modern Tower of Babel", but proposes eight more "independent" entities. McGrath et al comment timidly that a Productivity Commission suggestion for a national advisory council "has merit", and Dowton et al simply comment: "It is time to comprehensively review the oversight and governance of postgraduate medical education and training."

None of these articles even mentions General Practice Education and Training (GPET), an innovative Australian initiative. GPET was established in 2001 as an incorporated entity with a board appointed by the federal Minister for Health. GPET has established regional training providers (RTPs) across Australia. GPET is required under its constitution and government funding arrangements to provide postgraduate training according to standards determined by medical colleges.

For general practice, GPET provides features these authors find lacking in Australia's medical education arrangements, such as "overarching governance and coordination", "integrated mechanisms to draw together the interests of stakeholders", "alignment between workforce planning, education and training needs" and "alternatives to teaching hospitals".[4] GPET manages the interaction between autonomous colleges and a funding agency, and conflict between the focused desires of young doctors and workforce policies, while organising training outside public hospitals.

Change is difficult, perhaps more so in medicine than in other sectors. Michael Foot, once leader of the British Labour Party, reflecting on political differences with the British Medical Association, wrote: "Much the strongest bent in the medical mind was a non-political conservatism, a revulsion against all change, a habit of intellectual isolation which enabled them to magnify any proposals for reform into a totalitarian nightmare. Nothing good could ever come from the meddling of outsiders."[5]

GPET was a political response to effective lobbying from rural doctors rather than imposition of some grand centralist plan. Nevertheless, the imagined threat to professional autonomy evoked gloomy foreboding about "training standards spiraling downwards".[6] Maybe Dahlenburg, McGrath and Dowton realise controversy would follow any proposal for a medical education system with attributes they see missing, such as overarching governance, more coordination, alignment of workforce needs with trainee numbers, and wider distribution of training resources. It might require some consolidation of organisations, common structures and processes across disciplines, and some direction in the distribution of training resources.

Maybe these authors do enough by raising the issues and are wise to leave others to debate whether centralised control and coordination could solve the problems they describe. Maybe they took the advice of a well known Englishman and decided not to mention the war.[7]

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Medical student input to workforce planning

Ruth E Blackham, Ian R Rogers and Ian G Jacobs

To the Editor: We surveyed current medical students and interns in Western Australia over the 5 weeks from 23 September to 30 October 2005 to determine their awareness of, and views on, the imminent increase in clinical student and intern numbers as a result of federal government plans to increase medical student numbers nationwide, and to seek opinion on proposed strategies to cope with the demand on health education resources.