My name is Kyle Sheldrick, I graduated in medicine this year from the University of Western Sydney, about a fifth of our graduating class is working outside a capital city next year, the majority of these on the central coast of NSW, around Wyong and Gosford, but some are going further afield to Wagga Wagga and Alice Springs.

Despite going to a capital city based medical school I feel I have had good exposure to rural medicine.

In 2010 I spent just under two months in rural Queensland based out of the Mount Isa Base Hospital. During this time I flew with the Royal Flying Doctor Service to very remote towns such as Uranadangi on the border with the Northern Territory and to Boulia South of Mount Isa. I also visited a number of other towns within a few hundred Kilometers of Mount Isa, and treated patients from as far afield as Doomadgee to the North and from some small islands in the Gulf.

This year I spent time in Western NSW based at Wellington at the Aboriginal Medical Service, and in Dubbo with allied health workers in physiotherapy, occupational therapy and speech pathology at a service for Aboriginal children.

The point of these anecdotes is to say that in my personal experience significant exposure to rural and remote medicine exists in medical schools, even those located in capital cities, for anybody who wishes to take it.
I did not spend a year at a rural clinical school, although this opportunity is available to students at every Australian medical school.

Where such opportunities are not so universally available however is after graduation. I am aware through personal experience of a number of students who applied for an internship in a particular rural area through the NSW RPR (Rural Preferential Recruitment) Scheme who were unsuccessful due to the high number of applicants. I have met registrars (more senior doctors in training) who had a desire to work rurally but could not find training positions rurally in their chosen field. Imagine a doctor who graduates from medical school with a desire to work rurally at the age of 25. In all likelihood this doctor will then spend the better part of a decade training in an urban setting, marry and have children who may well start school in an urban setting and finishes training in their mid thirties having developed a family and strong ties to an urban area. Their aspiration to work rurally almost a decade earlier will carry much less weight.

In 2010, The NSW Medical Students' Council conducted a survey of 1,087 medical students in NSW (greater than one in four of all medical students at that time) which demographically (in terms of gender, age, prior degree and residency status) was reasonably representative of the student body. In this 75% indicated they were considering working rurally, more than two thirds of these (49.2% of all respondents, 521 respondents) however indicated that they were only considering working rurally only for part of their careers. Only 24.6% were not considering working rurally.

The problem in developing a sustainable rural medical workforce is not

"how do we graduate doctors who want to work rurally", we do that already. The problem is how do we develop a system post graduation that does not then tie these practitioners to an urban area during the period of their life when they are establishing and stabilising their relationships, family and professional networks. The answer to me is a strong system of postgraduate training at prevocational and vocational levels in rural Australia that allows doctors to develop skills and experience that are viewed as world class.

I am aware that there are proposals to build another non-capital city medical school in various parts of Australia, perhaps the most politically active of these is Charles Sturt University in Western NSW, whose proposal points to their (very impressive) figures for allied health graduates entering the rural workforce. These numbers are sadly not translatable to medicine, potential medicine graduates of CSU, in my opinion, will face the same shackling to urban centres for postgraduate training during the formative periods of their adult life and do little more than pump more doctors into established urban training centres. Unlike a physiotherapist or an occupational therapist, a doctor cannot simply set up their shingle and commence practice at graduation, doctors face at least a further half a decade before being qualified to practice independently in the bush.

Significant data of course exists about students studying rurally being correlated with intention to practice rurally at graduation, and this will no doubt be presented to you, yet I would ask the committee to look for evidence as to whether this actually translates to doctors working rurally rather than simply being an intention at graduation. I believe the reason such evidence does not exist is the point I have made above about the scarcity of postgraduate training in rural areas.

It is my considered opinion that an effective strategy to boost the number of doctors practicing in rural areas must be focussed around postgraduate training opportunities in rural areas, rather than basic medical school education.

Dr Kyle Sheldrick, M.B.B.S.
Former NSWMSC Chair (2011)