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PERSONAL VIEW

Rural Generalism and the Queensland Health pathway – implications for rural clinical supervisors, placements and rural medical education providers

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ABSTRACT

'The lifeline for country medicine' was the description by the Rural Doctors Association of Australia of the Queensland Health Rural Generalist Pathway (RGP). The program promises to redress rural medical workforce issues in Queensland. It may fulfil these promises, but only with the support of rural clinical supervisors and medical educators adapting to new expectations of competencies, of training structure and endpoints of training. These adaptations will be a key element of the RGP success, particularly as other states adopt the approach. This article outlines the lessons learnt and adaptations made by clinical supervisors and medical educators in the Queensland Rural Medical Education group, to deliver the Rural Pathway of the Australian General Practice Training program since the first registrars identifying as RGP appeared in this program in 2006.

Key words: Australia, general practice, Queensland, rural doctors, rural generalist pathway.

Context

'The lifeline for country medicine' was the description by the Rural Doctors Association of Australia of the Queensland Health (QH) Rural Generalist Pathway (RGP)[1]. The program promises to redress rural medical workforce issues in Queensland[2]. It may fulfil these promises, but only with the support of rural clinical supervisors and medical educators adapting to new expectations of competencies, of training structure and endpoints of training.

This article outlines the lessons learnt and adaptations made by clinical supervisors and medical educators in the Queensland Rural Medical Education group, to deliver the Rural Pathway of the Australian General Practice Training program since the first registrars identifying as RGP appeared in this program in 2006.

Australia has a distinct urban-rural inequity in health services, with fewer than half the number of medical practitioners per capita located in rural areas compared with metropolitan centres[3]. Queensland has the most ruralised population of the Australian states[4]. Specialist medical services are largely concentrated in the metropolitan southeast corner of the state. Outside this corner and a few regional centres, all permanent medical care is met by rural GPs with expanded skills and scope of practice.

Most medical services in rural Queensland are delivered by private rural GPs (n=1395 in 2010), some also hold public staff appointments in local rural hospitals part-time (n=100) and others practice full time in primary care QH rural hospitals (n=77)[5]. The Rural Generalist Pathway (RGP) emerged within QH to primarily address the latter workforce.

A QH rural generalist (RG) doctor is credentialed for rural hospital and community primary medical practice, hospital secondary care in at least one specialist discipline without supervision by a specialist in the discipline and [possibly] hospital and community-based public health practice, particularly in remote and Indigenous communities[6,7]. Obstetrics, anaesthetics, emergency medicine, surgery and Indigenous health are priorities for advanced skill training. More recently, internal medicine, paediatrics and mental health have been adopted for advanced skill training in the RGP.

The program arose from a workshop of Rural Doctors Queensland at Roma in 2005. The 'Roma Agreement' was developed and subsequently endorsed by Queensland Health. The Agreement goal was to develop and sustain an *integrated service and training program* to form a *career pathway* supplying the rural generalist workforce that the bush needs.

The Roma Agreement had nine principles including that educational standards of the RGP was to be set *externally* by the appropriate [medical specialist] College, and that vocational training would be provided by Regional Training Providers, funded by the Commonwealth Department of Health and Ageing General Practice Education and Training Ltd (GPET) to deliver the Australian General Practice Training (AGPT) program[8].

The QH RGP is structured to support the Fellowship curriculum of the Australian College of Rural and Remote Medicine[9]. The program also accommodates the rural program of the Royal Australian College of General Practice, leading to Fellowship in Advanced Rural General Practice in addition to FRACGP[10]. Training to College standards is delivered by a regional training provider (such as Queensland Rural Medical Education [QRME]) for registrars on the AGPT program, whether or not they are also on the RGP.

Employment benefits for RGP trainees include recognition of Rural Generalist Medicine as a *generalist discipline* attracting *specialist* pay scales[7,11]. After successfully completing an advanced skill training year and being credentialed and privileged in this advanced skill, trainees may be granted 'Provisional Fellowship' status to receive base specialist conditions. Trainees are also offered a longer employment contract with QH than other junior medical doctors, who typically are employed on year-to-year contracts.

There are significant training benefits for the RG. Hospital terms otherwise difficult to secure, such as paediatrics, anaesthetics and obstetrics, are guaranteed to RG interns and residents. The RGs also attend additional emergency skills workshops and have preferred access to protected training positions for selected advanced skill programs, most of which are centrally coordinated within QH and the RGP.

Those enrolled in the RGP are required to enter the AGPT program through competitive selection, as are all registrars.

Once successfully on the AGPT training program, RGs must progress through the education program provided by the selected training provider to remain eligible for the benefits of the RGP.

The QRME is a training provider supporting clinical supervisors in rural general practice and rural hospitals, delivering the AGPT program exclusively as a rural pathway. The QRME also conducts a large prevocational rural general practice placement program[12] and the Queensland Rural Medical Longlook Program[13-15], placing senior medical students into longitudinal rural placements.

At the end of 2011, QRME had recruited 51 registrars who were also enrolled in the QH RGP. Thirty had progressed beyond their second postgraduate year, of whom 24 had undertaken an Advanced Specialisation Term, including 17 who have now completed at least their first term in primary-care learning.

Lessons learned from this experience of students, junior doctors and registrars involved in the RGP relate to workforce, administrative and educational issues.

Issues

Medical workforce issues

Recruitment by the QH RGP from medical student ranks: Recruitment by the QH RGP from medical student ranks assumes that the decision to choose Rural Medicine is taken during the final years of medical school. There is reasonable evidence for this, and that nurturing rural interest in undergraduate years is a factor in career choice[16-18]. Exposure of Queensland medical students to Rural Medicine varies widely from nothing, to rural general practice terms, regional clinical school year-long placements, and up to full-year placements embedded in rural hospitals.

For those with limited exposure to Rural Medicine, recruitment to the RGP potentially leads to poor decisions by students committing to an employment pathway with insufficient information and experience. Perceptions of job security and advantages in accessing a training pathway in the increasingly competitive environment also motivate students to make decisions early. Not surprisingly, early cohorts of the RGP have included a high proportion of government scholarship holders who would be required to undertake rural service anyway. In its recent years of operation, the RGP has released participants whose career interests have changed. Notably, there is no return-of-service obligation for RGP participation, except for those on government scholarships.

In recent rounds of selections for the RGP, students not successful in selection felt that they needed to consider another career path since Rural Medicine was no longer available to them. This is a dangerous misperception for Rural Medicine. The RGP have subsequently increased counselling regarding other pathways to enter rural general practice postgraduate training. Vertically integrated training providers can not only provide exposure to Rural Medicine, but also clarity regarding vocational training pathways and role models to advise students and junior doctors and assist them to make informed career choices.

The primary focus of the RGP has been on full-time generalist positions in QH rural hospitals. Providing training benefits and enhanced employment conditions in rural hospitals has attracted registrars away from private rural general practice where the majority of vocational training places are available. An equilibrium balancing public and private medical workforce, including the RGP influence, will eventually be achieved; however, in the short term, rural training providers have a role to play in attempting to mitigate the disequilibrium from the introduction of the RGP overbalancing workforce towards public placements. Rural training providers must understand these market forces and act locally to balance the workforce as quickly as possible for the viability of private rural general practice.

Strategies must be devised to overcome barriers for private practices to recruit registrars and effectively compete with

the QH RGP. The most obvious barrier in our region is the cost of accommodation in rural communities due to increasing mining interests. Others include making available more consulting rooms, furnishing practices with suitable teaching resources, telemedicine and telemedical education, augmenting the limited workforce with medical students, and providing clinical supervisors with suitable professional development (and locum support) to integrate multiple levels of medical learners. Finally, an effective strategy supported by the Colleges, has been the use of blended or composite placements in which registrars employed and placed in QH rural hospitals are required to undertake some of their training in the local private practice. Funding models for this have been found and agreed with QH to successfully operate blended public-private training placements. These arrangements have been very successful for managing registrars on the RGP locally during these phases of general practice training.

In the long term, three effects will help balance the public-private rural medical workforce incorporating the benefits of the RGP. First, more applicants overall are attracted to a higher profile of Rural Medicine, partly brought by the RGP and training provider efforts to improve support for private rural general practice. This is certainly being seen in an increase in both numbers and quality of applicants for rural general practice training with QRME. Second, as training positions in larger RG-staffed hospitals fill, the RGP has responded by accepting the placement of participants in smaller rural hospitals staffed by doctors given the right of private (general) practice in their conditions of employment with QH. Third, as rural registrars complete training and settle into rural practice, they migrate out to private practice.

Administrative issues encountered

Selection for the AGPT program is competitive and becoming more so. Not gaining selection on the AGPT stops progression through the RG pathway. In recent selections for GP training positions, some interns on the RGP were not 'shortlisting' to final selection by training providers. Some did not pass the regionally specific question in the final interview process. In the cases recognized and managed to date, inexperience appears to be the major factor. As this issue evolves, it will be interesting to see whether the RGP could provide coaching for selection processes as part of the suite of additional training during prevocational years.

Recruits to the RGP secure highly competitive hospital rotations (such as anaesthetics and obstetrics) and advanced skill training positions as part of the program. Along the way, a number of registrars 'discover' that they actually wish to pursue a career in their hospital-based advanced skill during their year of specialised training, and change to these specialty College programs having already consumed the training positions in rural medicine. If these registrars undertake their advanced skill training immediately after residency, they may never serve or experience rural primary-care medicine.

It is very appropriate for registrars who are seriously considering careers in rural medicine or a hospital-based specialty to use an advanced skill training year as an opportunity to gather more information for a better career decision. However, supervisors and training providers need to be vigilant for registrars who are gaming the system to increase chances of entry into hospital-based specialty programs using the RGP.

Disproportionate advanced skill selection has occurred in these early years of the RGP. The focus of the RGP is on procedural advanced skills, and less so for higher-level skills in paediatric, medical and chronic disease management among rural GPs. The RGP participants are free to choose their field of advanced training. Anaesthetics and emergency medicine training have been very popular but obstetrics, surgery and Indigenous health less so. One effect has been that rural maternity and surgical services are not being adequately staffed despite available GP-anaesthetist registrars. A balance must be struck at least between GP-obstetricians and GP-anaesthetists. While this is not necessarily the responsibility of the training provider or clinical supervisors, it is certainly an issue at training places.

A related problem that can be managed locally by supervisors is the registrar wanting to only practice in an advanced skill area when arriving at their rural hospital placement. Registrars with advanced skills have been known to avoid general practice professional development. There are a number of signals. Poor motivation, not attending primary-care clinics, not undertaking private GP placements and not progressing through teaching resources or attending teaching sessions are some. These issues may be managed in partnership with the RGP. Reminding registrars that they are not entitled to continue on the employment conditions on the RGP unless progressing through GP training has worked.

Registrars who are also enrolled on the QH RGP may choose to train towards Fellowship in either the College of General Practice or the Rural and Remote Medicine College. There are some significant requirements in each College that do not exist in the other, such as mandatory terms, requirements for advanced training and accreditation of placements. Each College has it's strengths and both can produce good rural doctors, but supervisors and training providers must maintain familiarity with each curriculum and administrative process to advise on local application for relative benefits to individual registrars where they wish to train and practice. Additionally, each curricula, process and benefit needs to be placed in the context of QH regulations, policies and awards to produce a seamless local, tailored training program for the registrar. These are not inconsiderable requirements for supervisors and training providers to deliver.

Education issues

The training basis for the RGP is the Australian College of Rural and Remote Medicine curriculum that includes at least one year of advanced skill training. This year may be taken at any time after the post-internship hospital rotation year. The RGP prefers this to be completed in the third post-graduate year. The standard for the junior doctor to achieve in one year of training is that to allow *unsupervised* practice in the specialty. This raises some education issues.

The choice of advanced skill to develop must be made before practising as a registrar in rural medicine. The RGP provides guidance towards this decision within the scope of preferred advanced skill training and with some influence from the workforce needs of QH. This should be part of the decision process for registrars, but personal and family interests concerning the nature and location of training and rural practice should be paramount for the individual.

Options for advanced skill training recognized by the RGP are limited, reflecting workforce needs in the publicly funded rural hospitals. Both College curricula support training in many other valuable advanced rural skill areas. Training providers must provide a holistic counselling that considers family, future, placements, training options and provides frank advice as to whether the registrar is actually ready for the decision and advanced skill training.

Accreditation of advanced skill training placements is an important role of training providers. Accrediting and delivering suitable advanced training in a specialised field in preparation for rural practice is not the core business of tertiary hospitals, at least in Queensland. Regional hospitals are more suited to this role. In Queensland, regional hospitals drain directly from rural communities which places the specialty skill more readily into the rural context. Rural mentors and a training advisor dedicated to registrars in advanced skill training have been found necessary to emphasise the rural context, ensure the syllabus delivered is appropriate, and prepare these registrars for primary care practice the following year. Rural clinical supervisors with a broader scope of practice are ideal to provide rural context as mentors.

After completing an advanced skill training program, registrars not only enter learning in primary-care medicine, but also must consolidate and maintain their advanced skill. Finding suitable placements in QH facilities is sometimes difficult and always requires close and regular communication. Solutions to ensure progression in primary-care learning and consolidation of advanced skills may require multiple blended placements to be arranged.

There are conflicts between RG placements involving primary care and advanced procedural practice and the standards and guidelines of the AGPT program and, particularly, the RACGP training standards. Somewhat paradoxically, QH privileges RGP registrars to practice their advanced specialisation *without direct supervision* as they enter a closely supervised period of learning in general practice under the AGPT. Not only is it difficult to reconcile this conflict, it is also difficult to find clinical supervisors able to supervise in rural general practice as well as ensure safe practice and consolidation of an advanced skill. One solution found workable has been to have a primary clinical supervisor with co-supervisory arrangements to supervise the whole practice of the registrar.

Learner/leader conflict: Learner-leader conflict appears to occur among registrars who have acquired advanced skills early in their career and are expected to practice an advanced skill unsupervised while also undertaking their placement as a learner in general practice. Such placements will occasionally call on them to become a leader of the clinical team when their specialist skills warrant. Leading in a clinical situation is a considerable role to assume early in a medical career. To be also resolving and accommodating the transition to the learner role in primary care medicine is very difficult for some registrars. We have had several registrars become significantly distressed with these conflicts and responsibilities. They have been managed with time away from practice and personal health support. Good clinical governance should include monitoring for such distress by medical educators, and clinical supervisors being aware of this empirically higher risk situation.

Conclusions

There are particular issues confronting rural clinical supervisors and training providers associated with the RGP model in QH. These may vary with different models in other states; however, some lessons of the administrative complexities and the educational issues will remain relevant.

Rural generalism, like any change, causes disequilibrium in the medical workforce and education, however it has contributed to an increase in number and quality of applicants for rural general practice specialisation. Eventually a new equilibrium will be achieved in rural Queensland that will have changed rural medical education and further benefited rural communities. Rural clinical supervisors and training providers can learn from the experience in Queensland as this model expands nationally.

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