

# NOVA

## Public Policy Pty Ltd

**REVIEW OF THE QUEENSLAND HEALTH RURAL GENERALIST  
PATHWAY (RGP) MODEL TO EXAMINE WHETHER THERE IS THE  
POTENTIAL TO EXPAND THE MODEL NATIONALLY**

**FINAL REPORT**

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NOVA Public Policy P/L

ABN 97 122 236 453

**Canberra**  
PO Box 7444  
FISHER ACT 2611  
Tel: (02) 6231 6814  
Fax: (02) 6231 6914

**Melbourne**  
4 Thanet St Malvern  
Tel: (03) 9509 6116

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# 1 Glossary

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|         |  |
|---------|--|
| ACEM    | Australasian College for Emergency Medicine  |
| ACRRM   | The Australian College of Rural and Remote Medicine  |
| AGPT    | Australian General Practice Training   |
| AMS     | Aboriginal Medical Service (also known as Aboriginal Health Services)                            |
| ANZCA   | Australian and New Zealand College of Anaesthetists  |
| AON     | Area of health need categories based on priorities   |
| AST     | Advanced Skills Training   |
| CEmOC   | Comprehensive Emergency Obstetric Care   |
| CME     | Continuing medical education   |
| CSQTC   | Central and Southern Queensland Training Consortium Ltd (a Queensland RTP providing GP training) |
| EmOC    | Emergency Obstetric Care   |
| FACRRM  | Fellow of the Australian College of Rural and Remote Medicine                                    |
| FARGP   | Fellowship in Advanced Rural General Practice  |
| FRACGP  | Fellow of the Royal Australian College of General Practitioners                                  |
| GP      | General Practitioner   |
| GPET    | General Practice Education and Training Limited  |
| GPPTP   | GP Procedural Training Program (term used in NSW)  |
| IMG     | International Medical Graduates  |
| MO      | Medical Officer (in hospital employment)   |
| MSRPP   | Medical Superintendent with Right of Private practice  |
| PGY 1-3 | Number of years after graduation (Post Graduate Year)  |
| QRGP    | Queensland Rural Generalist Pathway  |
| QRME    | Queensland Rural Medical Education (a Queensland RTP providing GP training)                      |
| RACGP   | The Royal Australian College of General Practitioners  |
| RACS    | Royal Australasian College of Surgeons   |
| RANZCOG | Royal Australian and New Zealand College of Obstetricians and Gynaecologists                     |
| RGP     | Rural Generalist Pathway   |
| RHW     | Rural Health West  |
| RTP     | Regional Training Provider   |
| RVTS    | Remote Vocational Training Scheme  |
| SMO     | Senior Medical Officer   |
| SMORPP  | Senior Medical Officer with Right to Private Practice  |
| TMT     | Tropical Medical Training (Queensland RTP providing GP training)                                 |
| VMO     | Visiting Medical Officer (called a VMP in Western Australia)                                     |
| VMP     | See VMO  |
| WACHS   | Western Australian Country Health Service  |
| WAGPET  | Western Australian General Practice Education and Training Ltd                                   |

## 2 Executive Summary

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NOVA Public Policy was contracted by the Department of Health and Ageing in mid 2010 to undertake a review of the Queensland Health Rural Generalist Pathway (QRGP) model to examine whether there is the potential to expand the model nationally. The work included a literature review and consultations with key stakeholders across Australia. Key themes that emerged from the literature (see Appendix C Literature Review) included:

- the increasing demand for general practitioners with procedural skills is an international phenomenon resulting in the implementation of specific education strategies, regulatory and accrediting arrangements and coordination of effort by key stakeholders
- the increasing reliance on rural procedural GPs where rural communities cannot sustain specialist services including in Australia, indicates the need for targeted strategies to increase both the number and proficiency of rural proceduralists
- there is a need to develop articulated training pathways (in both hospital and community settings), mechanisms to ensure safe practice within site specific limitations and provision of remuneration and other incentives appropriate to the nature and location of practice
- there is a need for intersectoral work involving all key stakeholders to ensure that efficiencies, cross-accreditation and educational arrangements are optimised.

### 2.1 Description of the Queensland Health Rural Generalist Pathway (QRGP)

The QRGP:

- was initiated to address supply issues for Queensland's rural and remote medical workforce; the first cohort of trainees commenced in 2007 and will graduate in 2011
- is a fully supported, incentive based career pathway for junior doctors wishing to pursue a vocationally registered career in Rural Generalist Medicine. Rural Generalist Medicine was recognised by the State as a medical discipline in May 2008.
- provides attractive remuneration and career opportunities for medical officers wanting to work in rural and remote Queensland
- is aimed primarily at final year medical students, though post graduate entry is possible
- cover the priority specialised disciplines, based on Queensland workforce shortages, of anaesthetics, obstetrics, emergency medicine, Indigenous health and surgery.

QRGP trainees are employed as hospital medical officers providing general practice as an outreach of the hospital service or with rights of private practice. There are currently 146 <sup>1</sup>trainees, almost equivalent to the total number of SMORPPs, SMOs and VMOs<sup>2</sup> currently working in rural Queensland; representing a significant increase in the rural, primary care workforce

### 2.2 Other jurisdictions

Other jurisdictions also rely on rural GPs with advanced procedural skills to provide or supplement specialist services but have defined their role specific to each jurisdiction. While the term "generalist" is often applied to these doctors, no other jurisdiction defines a rural generalist in the same way as Queensland (a salaried employee) although the NT is proposing to adopt the QRGP model, subject to development of cooperative training arrangements and a new award structure for GPs with advanced skills.

In other jurisdictions generalists are usually engaged through Visiting Medical Officer (VMO) contractual arrangements: NSW Health continues to support for advanced skills training of rural GPs but is also developing a new career structure for generalist salaried medical officers with advanced skills (*hospitalists*) who will work across all geographic settings; WA is developing its own version of a RGP training model and will continue to use rural GPs with advanced skills on a VMO basis; and SA and Victoria are continuing to develop their existing arrangements for training of rural GPs with advanced skills with VMO rights.

### 2.3 Stakeholder feedback on the QRGP

All medical Colleges consulted for this review recognised the unmet demand for specialists' services in rural/remote Australia. While they would prefer fully trained specialists to deliver specialist services, they recognise that in remote areas, GPs are often relied on to fill any gaps. However the Colleges noted that Rural Generalists/GP Proceduralists must provide services appropriate to their level of proficiency and whilst recognising that rural GPs with procedural skills are part of service delivery in non-metropolitan areas they should not be seen as an alternative specialist workforce.

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<sup>1</sup> According to figures provided by Queensland Health June 2010

<sup>2</sup> Senior Medical Officer with Right to Private Practice (SMORPP), Senior Medical Officer (SMO) and Visiting Medical Officer (VMO)

RDA strongly supports a national roll out of core features of the QRG, with jurisdictional variations to accommodate differences in procedural and primary health care service delivery and workforces.

## 2.4 Transferability of the QRG across jurisdictions

The Queensland model has many specific features which have shaped the development of the QRG and which may impact upon its transferability across jurisdictions. These include the very extensive rural and remote areas with medical officer shortages, direct management of public health services by Queensland Health, and Queensland Health's strong engagement in rural and remote health workforce development. Challenges experienced by the QRG are common challenges in other jurisdictions and include:

- availability of accredited training posts in rural areas
- employment arrangements that address the needs of all stakeholders
- competition between specialist and rural generalist trainees for limited AST<sup>3</sup> posts
- funding for the training and supervision provided by practitioners
- release of trainees from community employers to meet their training commitments
- concerns of rural trainees that they may be disadvantaged in gaining access to specialist training programs compared to metropolitan trainees
- balancing the demands of primary health care training in community settings with procedural training in hospital settings.

However key elements of the QRG that may be transferable are provided below.

1. Engagement and agreement from key stakeholders through implementing integrative processes and structures such as consultative committees and credentialing committees with membership drawn from all relevant stakeholders.
2. Quarantined training places for rural trainees and implement strategies that aim at retaining doctors in rural and remote communities including rural GPs who wish to maintain a commitment to their rural and remote hospital services.
3. An integrated, coordinated and supportive system for the selection, training and placement of trainees coupled with:
  - an appropriate orientation to primary health care practice
  - provision of a range of training environments to enable the development of a responsive and flexible primary care workforce with the range of skills to meet the needs of the community, including access to training in community based general practice environments and procedural posts
4. Employment arrangements by defining the role for the rural generalist/rural GP with advanced skills within professional and employment structures and in doing this, pay attention to addressing any potential disparity in recognition and reward between general practitioners and rural generalist/ rural GP with advanced skills.
5. Adequate resourcing to cover all aspects of training delivery and support for it.
6. Arrangements for training and credentialing of trainees that are agreed by all the relevant bodies.
7. A high level of vocational support to rural trainees throughout their training, including career counseling, career planning, sympathetic placements and active problem solving.

## 2.5 Conclusion

Alternative models of health financing, models of interprofessional practice, jurisdictional responsibilities and professional demarcations are all under review, and demographic and lifestyle expectations are impacting upon workforce structure and expectations. In this context, traditional modes of general practice are likely to change considerably over coming years. The challenge will be to prepare a workforce to meet those future requirements. While it is not possible to accurately define future primary health care practice, it might be anticipated that a generalist workforce with a capacity to work flexibly in a range of environments, both procedural and ambulatory, would be well placed to respond to these new models of service provision.

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<sup>3</sup> Advanced Skills Training (AST)

## 3 Project Outline

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### 3.1 Project background

Rural Generalist Medicine had its Queensland origins as a generalist discipline in medicine following a meeting of key stakeholders who convened in Roma in August 2005, to develop the concept of a supported training pathway to a career in rural medicine. Prior to this, Queensland's decentralised population outside of the major coastal and regional centres depended on a contracting workforce of about 80 hospital-based generalist practitioners supported by a smaller and also contracting number of procedural rural general practitioners. They provided specialist-level medical care in disciplines such as obstetrics, anaesthetics and surgery<sup>4</sup>.

The Queensland Health Rural Generalist Pathway (QRGP) was developed from this, as a fully supported, incentive based career pathway for junior doctors wishing to pursue a vocationally registered career in rural generalist medicine. It provided attractive remuneration and career opportunities for medical officers wanting to work in rural and remote Queensland. QRGP had its first intake of trainees in 2007 and Rural Generalist Medicine was recognised by the State as a generalist discipline in May 2008.

Whilst there are many common features across jurisdictions with respect to medical officer shortages, there are also significant differences related to local workforce profiles, organisational structures and service provision. Consequently the Queensland model has many specific features which have shaped the development of the QRGP. These include the very extensive rural and remote areas with medical officer shortages, direct management of public health services by Queensland Health and Queensland Health's particular approach to rural and remote health workforce development.

### 3.2 The project work

This review project was required to clearly describe the critical elements of the QRGP model, and examine the potential for these elements to be transferable to other jurisdictional contexts and to meet their specific needs. The review entailed:

- a descriptive or process review including describing and mapping implementation activities of the rural generalist program model(s)
- a review of the outcomes for trainees and jurisdictions
- a meta-review including the degree to which the QRGP model is transferable to other contexts, taking into account their different environments, needs and organisational arrangements and the changes that might be required.

### 3.3 The project team

The NOVA Public Policy team that undertook work on the project was Ms Lorraine Wheeler who managed the project. Dr Tom Keating, Dr Derek Weir and Mr. Tony Wade designed and conducted consultations, and undertook analysis of data collected to develop the report for the Department.

### 3.4 Details of Project activities

The project proceeded through five interconnecting stages:

**Stage 1: Project initiation.** During this stage the project team was briefed by key informants to establish the framework for the research project followed by a review of the literature and other documentation ( See Appendix C Literature Review) to develop the analytic framework to be used for data collection, coding and analysis. (See Appendix B Review questions per stakeholder group )

**Stage 2: Development of a detailed description of the RGP.** During this stage the elements of the QRGP model were explored and described within the analytic framework. In addition to the policy, program and available evaluative documentation, data sources included interviews with key informants within Queensland Health,

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<sup>4</sup> Queensland Government (2007). A brief history of the Rural Generalist Pathway, August 2007. [www.health.qld.gov.au/ruralgeneralist/docs/brief\\_history.pdf](http://www.health.qld.gov.au/ruralgeneralist/docs/brief_history.pdf). Accessed 07/05/10



educational and accreditation organisations, professional associations and Learned Colleges operating within Queensland. (See Appendix A Stakeholders consulted)

**Stage 3: Collection of data on RGP models in other jurisdictions.** During this stage similar data was collected on models developed in other jurisdictions and recorded within the analytic framework for comparison with the QRGP model.

Consultations were also conducted with other stakeholders including all relevant learned colleges, GPET and the RDAA to identify how the model is perceived by them, including benefits and/or adverse impacts. (See Appendix A Stakeholders consulted).

**Stage 4: Evaluation of QRGP model.** During this stage a report was developed including a description of key components of the QRGP and advice about the applicability of the QRGP to different contexts.

**Stage 5: Development of Final Report.** Taking into account the literature review, descriptive analysis of the QRGP and other jurisdictional models and the consultations this Final Report was developed in accordance with the Review Project's Terms of Reference.

## 4 Context of the review project

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The challenge of providing appropriate health services in rural communities is highlighted by the extract below from the website of Western Australia Country Health Service (WACHS) which identifies the size of the population to be serviced, the spread of the population over a very extensive area and the need to provide for the full range of health services for patient groups.

*“The Western Australia Country Health Service provides health services to approximately half a million people, over a vast 2.5 million square kilometres area ... and handle almost as many births as the State’s major maternity hospital and as many emergency presentations as Perth metropolitan hospitals combined. The range of health services provided cover primary health care, emergency and hospital services, population health, mental health, Indigenous health and aged care.”<sup>5</sup>*

Coupled with the challenge of the scope of the health service delivery is the difficulty in attracting and retaining the required skills set. This is well documented, including in the Productivity Commissions report (2005) into the health workforce<sup>6</sup> which stated that *“many rural and remote communities do not have the ‘critical mass’ necessary to support resident specialists — not only in terms of population, but also in meeting related infrastructure requirements....A major theme in submissions to this study (the Productivity Commissions report) has been that access to health services in rural and remote Australia is inferior to that in the major population centres, and that these access difficulties are worsening. In a health workforce context, the primary concern is insufficient numbers of health workers — especially general practitioners, medical specialists and some allied professions. However, a variety of problems relating to skills mix, scopes of practice and recruitment and retention have also been raised.*

*At the same time... these areas have been an ‘incubator’ for developing and testing new models of care and expanded scopes of practice. Many such innovations have the potential to provide the basis for system-wide changes in health workforce arrangements in coming years.”*

This review project was commissioned to examine one such innovation, the Queensland Health Rural Generalist Pathway (QRGP) and examine the potential for the critical elements of it to be transferable to other jurisdictional contexts and to meet their specific needs. Other jurisdictions have developed their own model for addressing their own rural workforce and service delivery issues were also examined.

The Chapters 6 and 7 of this report describe these models and examine:

- the success and effectiveness of the RGP models especially in relation to improvement in numbers of GPs with procedural skills working in rural and remote locations and the range of settings in which they work
- whether the QRGP model could be implemented in other jurisdictions including any benefits and/or barriers to implementation, including potential cost implications for funding bodies
- the potential impact upon the GP workforce, including any impact on regions not targeted for funding through the program)
- any benefit or adverse impacts of the QRGP model on other stakeholders including GPET, RACGP, ACRRM, other learned colleges and the RDAA
- the relationship between the QRGP model and the Australian General Practice Training (AGPT) program and any implications, should a national expansion of the QRGP model occur
- alternative national models or practices that may be more effective.

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<sup>5</sup> <http://www.wacountry.health.wa.gov.au/>

<sup>6</sup> P 206 Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra.

## 5 Literature Scan

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A broad scan was undertaken of literature relevant to rural generalism, including both scholarly and grey literature. This was not a formal systematic review of all scholarly reviews but undertaken as a mechanism to inform the analytic framework of this consultancy. The literature review is provided in full at Appendix A. A summary of that review is provided below.

### 5.1 Workforce expectations

The literature notes that the medical workforce is changing as are the lifestyle aspirations of general practitioners. This has impacted upon the rural medical workforce and the structure of primary care and procedural services in rural areas.

In addition to these personal factors, breadth and scope of practice appear to be significant factors affecting decisions about a rural family medicine/general practice career. There is also a positive relationship in family medicine between higher overall job satisfaction and doing a wide range of procedures; postgraduate training in general internal medicine, general surgery, anaesthesiology, paediatrics and gastroenterology were reported to be positively related with the intention to continue a rural career.

### 5.2 The requirement for rural generalists

The requirement for general practitioners with procedural skills is an international phenomenon. There is a long history of provision of primary care services combined with procedural services in the UK, Canada and Australia. Obstetrics, emergency medicine and anaesthetics figure prominently in the literature.

The need for a rural generalist workforce in Australia has been supported by a range of inquiries, reviews and research. These have included *Improving Maternity Services in Australia: The Report of the Maternity Services Review*; the Australian Primary Health Care Research Institute study: *The Expanding Role of the Rural Generalist in Australia - A Systematic Review*; and the WA Country Health review: *Engaging Rural Doctors*.

Specific proposals for the development of rural generalist pathways were put forward through the Rural Health West consultancy: *Rural Generalist Pathway, Western Australia* and from the position paper on the training for GP Surgical Proceduralists by the Royal Australasian College of Surgeons.

### 5.3 Scope of practice

International research suggests that in rural areas the scope of practice of primary care physicians is extremely broad, covering many areas of primary health care and procedural medicine. The requirement for an extended scope of practice appears to be greater where disadvantaged communities are served.

### 5.4 Training requirements

There is a requirement for the provision of appropriate training for rural general practitioners with procedural skills and the international research that was reviewed, identified gaps in the training of GP proceduralists particularly in emergency medicine.

In response to a perceived lack of advanced skills training in support of rural generalists, a number of initiatives were reported, with mentoring and practical skills development identified as important in maintaining procedural skills.

In many countries there are education strategies in place to enhance the attraction and retention of a rural medical workforce and to ensure that that workforce has the skills to perform the required tasks. Some argued however that this has not gone far enough, particularly with respect to the preparation of rural proceduralists.

A number of initiatives are identified in the literature including organisation and coordination among educational programs committed to training surgeons for rural practice and comprehensive EmOC<sup>7</sup> (CEmOC) training program for general medical officers involved in emergency medicine

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<sup>7</sup> emergency obstetric care (EmOC) and Comprehensive Emergency Obstetric Care(CEmOC)

## 5.5 Organisational and policy requirements

A number of initiatives are identified internationally, which seek to protect and extend the roles of rural generalists. These involve:

- the establishment of regulatory and accrediting bodies and the development of coalitions of interest amongst stakeholders
- organisational and policy initiatives which support the development of rural generalism
- establishing supportive processes, for example those associated with accreditation (by the Australian College of Rural and Remote Medicine - ACRRM), with standards and training provision (by the Australian Medical Council - AMC) and establishing professional bodies for rural hospital generalist doctors (as in New Zealand).

Impediments at this level to support the role of rural generalists highlighted the need for successful intersectoral work, including involvement by key stakeholders; the development of decision-making mechanisms; clearly defined objectives, roles and responsibilities; official support and legitimisation from participating organisations; and adequate resourcing for partnership building.

## 6 Description - key elements of the QRGF

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### 6.1 Background to the program

The QRGF was initiated in 2005:

- to supply a capable medical workforce for rural and remote communities
- in response to an anticipated decline in the rural medical workforce
- to address concern about the capacity to manage an International Medical Graduate (IMG) workforce to respond to the demands of relatively isolated and unsupported rural practice
- in recognition that Australian graduates seeking to establish a career in rural general practice did so with little structural support
- as a specific response to the workforce and clinical service needs in Queensland.

It was developed through detailed discussion with the Australian College of Rural and Remote Medicine (ACRRM) and provides a pathway to credentialing by ACRRM and the Royal Australian College of General Practice (RACGP).

The recognition of Rural Generalist Medicine as a medical discipline in its own right in 2008 provides career opportunities for those medical officers with aspirations of working in rural and remote Queensland as a rural generalist<sup>8</sup>. It took its first intake in 2007.

A Rural Generalist in Queensland is defined as a rural medical practitioner who is credentialed to serve in:

- hospital and community-based primary medical practice
- hospital-based secondary medical practice, without supervision by a medical specialist in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery; and
- hospital and community-based public health practice.

The impetus for the QRGF lies in the demographic of rural Queensland and the prevailing medical service model(s). Queensland has a distributed population and significant number of major rural centres.

The QRGF provides for employment by Queensland Health in training posts located in a select number of hospitals across rural and regional Queensland and an articulated career pathway that recognises certifiable advanced procedural skills obtained in the course of training, as well as training time towards seniority.

The QRGF provides:

- an advisory and support service comprising experienced rural medical and administrative staff who assist junior doctors
- quarantined training opportunities at select rural generalist training hospitals providing access to priority terms including in paediatrics, obstetrics and anaesthetics
- attendance at an intensive two and a half day simulated, procedural skills workshop in both postgraduate years one and two (PG1&2)
- support and advice regarding appropriate Advanced Specialised Training (AST) posts
- possible access to the Senior Medical Officer (SMO) pay scale as a Provisional Fellow based on merit selection, following successful completion of the prevocational skills and advanced specialised training in a nominated discipline matched to the position description of the prospective position.

The QRGF has three critical elements; a clinical education component; an industrial or career component; and a vocational support component.

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<sup>8</sup> Queensland Health. (2010). "Rural Generalist Pathway." Retrieved 4 April, 2010, from <http://www.health.qld.gov.au/ruralgeneralist/>.

## 6.2 Trainee profile

At the time of writing there were 146 trainees across the years of the pathway, with 43 interns in pre-vocational training in 10 hospitals in regional centres. There are 38 trainees accepted for admission in 2011 though this number will increase to accommodate some interstate applicants. In 2012 the number of interns in pre-vocational training will increase to 55. This is a substantial addition to the rural medical workforce. Although there is some concern that there may not be sufficient rural practice positions available for trainees it is likely that retirements amongst current practitioners, suppressed demand because of inadequate workforce supply and increased utilisation of fractional appointments will create an increased demand over time.

Regional training providers (RTP) describe the trainees within the RGP as being:

- generally younger and single relative to non –RGP trainees
- Australian
- with more rural experience and motivation towards rural practice
- very clear as to where they wish to go with their careers. A significant motivator appears to be the guarantee of a procedural post on completion.

Queensland Health identified leadership potential as a distinguishing feature of the current cohorts of trainees.

## 6.3 Trainee selection

Selection into the QRGP was initially through a ballot process for applicants for post graduate training posts in Queensland Health. The two subsequent intakes of final year medical students have utilised selection criteria associated with the applicant's rural background, preparedness for rural practice, and capacity to complete the pathway.

## 6.4 Outcomes and trainee destinations

The first cohort of trainees is about to finish but it is not known whether they will persist in rural practice. Trainees interviewed through this project have indicated that this is their intention, though they are unable to make a commitment for the longer term.

Queensland Health's own informal surveying of trainees suggested that the majority see their ultimate future in emergency medicine or other specialism in regional areas or medical leadership in regional centres. Consequently Queensland Health is anticipating that trainees will remain in their positions a minimum of 5 years but there is no presumption that they will remain permanently in these positions.

## 6.5 The academic program

### 6.5.1 Underpinning principles

The principles underpinning the QRGP training program were articulated at a workshop involving Queensland Health and key educational, professional and workforce agencies held in Roma in 2005. These principles include:

- Providing a fast track into rural placement. This recognises that affiliation with rural practice is best established early in a medical career.
- Completion of Advanced Skills Training. This was brought forward to 3<sup>rd</sup> year rather than at the end of training and prepares the trainee for early placement into designated procedural posts in rural settings.
- Enabling every rural post in Queensland Health as a potential training position. Rather than designating particular training posts in which trainees may be placed for training, placements can be in designated positions in which the trainee may stay on completion. RACGP criteria for the accreditation of posts were applied to Queensland Health hospital placements and all met the accreditation standards.
- Perceiving the QRGP as a pathway. Training should not assume that rural generalist practice is a definitive career choice and trainees should be prepared for a range of career choices subsequent to rural medical practice. Consequently the QRGP seeks to prepare participants for hospital based medical practice, provide them with advanced skills training in a designated discipline, and prepare them for a career in general practice or community health.

- Meeting workforce needs. The QRGP is focused on the training of a workforce to meet the service needs of rural Queensland rather than Queensland Health specifically.

### 6.5.2 Credentialing

The QRGP provides a three phase training program of pre-vocational training, advanced skills training and vocational training leading to vocational practice. It has a clinical education program extending over four years and leading to credentialing by ACRRM, RACGP or both colleges, depending on the Fellowship enrolment of the trainee.

Credentialing as a Rural Generalist requires Fellowship of ACRRM (FACRRM) including certified completion of advanced specialist training in one of the nominated key disciplines or Fellowship of RACGP (FRACGP) plus Fellowship in Advanced Rural General Practice (FARGP) including certified completion of Advanced Specialist Training (AST) in one of the nominated key disciplines and evidence that the ACRRM Curriculum Statements for obstetrics and women's health have been obtained (except where the certified advanced specialised training skills is in Obstetrics and Women's Health).

ACRRM credentialing is identified by Queensland Health as being more closely aligned with the objectives of the QRGP, but those trainees who choose RACGP credentialing or choose to pursue both, are equally supported. RACGP while initially opposed to the RGP, now formally endorses it.

Some misinformation appears to exist about the recognition of FACRRM credentials, with suggestions that the credentials are not recognised in other jurisdictions, are not accepted for urban general practice or not acceptable internationally. This is not the case as FACRRM has been approved by the Minister of Health and Ageing as a recognised medical specialty, and ACRRM gained initial accreditation by the Australian Medical Council in February 2007.

An independent pathway to Fellowship through ACRRM is also available whereby candidates can track through an individually determined course of training, independent of AGPT. This provides another alternative to achieve rural generalism in jurisdictions other than Queensland. Sixty four candidates have enrolled in the next cohort to undertake this pathway.

### 6.5.3 The structure of the education program

Pre-vocational training and Advanced Skills Training (AST) is managed and provided by Queensland Health. Trainees are then placed in training posts which are managed by Regional Training Providers (RTP). This training is largely provided by the RTP and funded through AGPT.

#### Training provision

It was reported by those consulted, that RTPs were initially wary of the QRGP as they saw it as potentially drawing quality trainees away from mainstream general practice and there was some concern that Queensland Health might seek to become its own RTP. However after some years of operation of the QRGP, these concerns have been largely dispelled among the RTPs and MoU's exist with the training providers; and the three Queensland RTPs interviewed as part of this project, strongly endorsed the QRGP. One of the RTPs consulted did however express concern that with the larger number of trainees choosing to become part of the QRGP, there were now insufficient places for non RGP trainees to be placed in private general practices and Aboriginal Health Services.

#### AST

A distinguishing feature of the academic program is that Advanced Skills Training (AST) occurs in the early stages of training (PGY3). Advanced Skills Training is identified as a pivotal point in the training program and critical for quality in clinical practice in the State. It allows trainees to be placed immediately into procedural posts in Queensland Health facilities, bringing about an immediate increase in the advanced skills trained workforce in the State. Completion of the AST is accredited by the relevant specialist college where there is an appropriate certificate (e.g. Advanced DRANZCOG in the case of Obstetrics and Gynaecology), or by ACRRM and RACGP where this is not the case.

The QRGP is the identified pathway to a rural emergency medicine specialist. Following completion of the QRGP with AST in emergency medicine and a post fellowship placement of 18 months to 2 years a Fellow may be

credentialed by ACRRM in generalist emergency medicine with equivalence industrially, in Queensland to a specialist in emergency medicine. ACRRM indicated that priority areas for development are with respect to rural emergency medicine and generalist surgery.

Queensland Health is moving towards a process of consolidation and statewide consistency with respect to curriculum and placements within post graduate medical training. To this end, consultative committees have been established with the relevant colleges of anaesthetics, obstetrics and gynaecology, surgery and emergency medicine.

#### **6.5.4 Primary Care/General Practice components of training**

One of the RTPs expressed the view that all trainees should be required to undertake a six month embedded placement within a traditional private general practice. The RACGP also stated that all FACRRM or FRACGP and FARGP delivered through the QRGP should have experience in community general practice.

Queensland Health rejects placement in a general practice as a compulsory component and that it provides no additional educational value though it is happy to support any trainee who wishes to undertake such a placement.

Consultation with a key academic, who is also a censor for ACRRM, perceived the issue as being more about the acquisition of experience and skills in primary health care rather than in general practice as such i.e. the requirement for skills and competence in primary health care are defined in the standards and candidates will not be credentialed as a Fellow if they were unable to demonstrate them.

ACRRM noted that its Fellowship program includes ten approved disciplines, the majority of which are not procedural. These include Indigenous health, population health, remote medicine, mental health and women's health. Each of these is available to trainees in the QRGP.

Queensland Health has however indicated that it gives priority to procedural skills because of a need to repopulate these disciplines and address quality and safety issues in rural procedural practice. They reported that a consequence of the program has been a significant re-establishment of procedural disciplines in rural and regional settings, for example the re-establishment of obstetrics in Cooktown.

Queensland Health, ACRRM and one RTP also reported that the scope of rural practice in Queensland is broad with a great capacity for engagement in preventative health and the RGP is having a significant positive impact by training registrars in procedural skills in the context in which they will be required to practice. There were, however some challenges identified for the QRGP including the need to provide a focus on the training of clinical supervisors in advanced skills training, and given the undertaking of advanced skills training in PGY3, a requirement to consolidate these skills through the remainder of the training program.

Additionally, it was identified by those consulted, that graduates of the RGP are more likely than their urban counterparts to find themselves in senior roles in hospitals or general practices requiring additional training in business and medical management.

## **6.6 Employment conditions**

Historically Queensland Health has had three principal means of engagement of medical officers:

1. the Medical Superintendant with Right of Private Practice (MSRPP)
2. the salaried medical officer (SMO)
3. the visiting medical officer (VMO).

MSRPPs have provided both procedural and ambulatory services in major centres and have carried a critical on-call responsibility. SMOs have been attached to hospitals and have had procedural responsibilities with respect to obstetrics, anaesthetics and emergency medicine. Unlike some other states, VMOs are a minority of medical officers in rural Queensland.



The 2005 Medical Enterprise Bargaining Agreement in Queensland Health led to industrial recognition for the first time, of non-specialist medical disciplines and the classification of disciplines in medicine. The *State Recognised Practice Reform Process* utilised the Australian Medical Council process for establishing medical credentials. It led in 2008 to the formal recognition in Queensland of the discipline of Rural Generalist Medicine, affording QRGP graduates industrially professional status equivalent to other medical specialists as well as defining their scope of practice.

The QRGP provides the opportunity for attractive conditions of employment which include industrial recognition as a medical specialist, advanced employment standing and attractive rates of remuneration. Salaries available to graduates are in the order of \$340,000 to \$380,000 per year, equivalent to other specialist salaries. Trainees are salaried during their training by Queensland Health and the training program is integrated with their employment experience.

During the course of training, participants in QRGP can achieve two certifiable post-graduate qualifications accepted by Queensland Health by their fourth year:

- a pre-vocational qualification accredited by ACRRM or RACGP
- discipline-specific AST accredited by ACRRM, RACGP or the relevant specialist College.

This gives them a certified scope of practice and allows them to be designated as Provisional Fellows and appointed as Medical Officers with Right of Private Practice or Senior Medical Officers. This provides for appointment at Level 13 within the Queensland Health salary scale with a salary in the order of \$200,000 (compared with a registrar's salary of \$90,000).

After completion of the remaining two years of the QRGP and their credentialing as Fellows, they are able to achieve a classification of Senior Medical Officer Level 18. This provides a significant incentive to remain within the pathway until completion and to remain within Queensland Health post-fellowship.

In undertaking Advanced Skills Training, trainees are encouraged to identify their preferred focus, and a number have chosen non-procedural fields of practice including internal medicine and mental health. They are advised however to plan their careers with regard to service demand: current workforce priorities in rural medicine in Queensland are in the areas of obstetrics, anaesthetics, emergency medicine, surgery and indigenous health. ACRRM reports that in those circumstances where an individual trainee's program require release for a term to be spent within a primary care setting and this can not be met within a small hospital environment, Queensland Health has facilitated release of that trainee.

One of the RTPs interviewed identified that as hospital posts were being progressively filled, trainees were increasingly being placed with Medical Superintendents with Right of Private Practice, Senior Medical Officers and Visiting Medical Officers. It was his view that progressively QRGP was broadening its scope both with respect to the type of placement and scope of practice. While recognising the workforce priorities of Queensland Health, he is an advocate for advanced skills training in internal medicine and public health practice.

## 6.7 Vocational support

Trainees identified that the vocational support element of the QRGP was a critical aspect for them and that was a reason for both undertaking and continuing in the QRGP. This support includes accommodating both employer requirements and trainee's career goals, sympathetic placement in training posts and responsiveness to personal and family requirements (called *case management*).

Queensland's long standing Rural Scholarships program provides an annual grant of \$21,000 for medical students willing to commit to a career in rural practice, with return of service obligations. Prior to the QRGP it had been struggling to attract applicants and had a high breach rate with a minority of scholarship holders proceeding to rural practice. With the initiation of the QRGP, 100% of rural scholarship holders have elected to proceed to designated rural pathway internship posts and applications for QRGP internships now significantly exceeds the number of scholarships. Preferences for training places expressed by rural scholarship holders have rated Rural Generalism as a clear preference, followed by emergency medicine and anaesthetics, and then general practice. This supports the view that scholarship holders are choosing QRGP as a career choice in its own right rather than as a means of pursuing a general practice career. Were the QRGP not available it may be anticipated that they would elect for places in sub-specialties.

Elements of the training program are designed to be responsive to the needs of trainees so that, for example, undertaking the Advanced Skills Training in 3rd year is designed in part to avoid costly and disruptive moves for trainees and their families in the course of undertaking the QRGP.

It is accepted by Queensland Health that within the QRGP the location of Advanced Skills Training early in the pathway may facilitate transfers out to other specialisms, and for some this may represent a better option. However, the selection processes, the vocational support and guidance and the influence of peers within the trainee cohort appears to mitigate against this. Loss to other specialisms from the RGP appears to be less than 5% for all trainees that have commenced QRGP to date.

## 7 Description of similar models operating or being considered for implementation in other jurisdictions

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The following is a summary of the outcomes of consultations and research into similar models either being considered or in operation in other jurisdictions.

### 7.1 New South Wales Department of Health

#### 7.1.1 Context

##### Practice Procedural Training Program (GPPTP)

The closest New South Wales equivalent to the QRGF is the New South Wales General *Practice Procedural Training Program (GPPTP)* which has been operating since 2003. GPPTP specifically targets GPs and GP Registrars. The original intent of GPPTP was to up-skill post-Fellowship GP VMOs for hospitalist roles, but it now addresses procedural training for both GPs and Registrars. This program is further described below.

##### Hospitalist program

New South Wales also introduced a pilot “hospitalist” program in 11 hospitals in 2007, based on similar programs in the United States. This is a medical workforce initiative to address generalist skills in all hospitals. It reflects the New South Wales Health recognised need to:

- improve generalist training opportunities in both the medical and the nursing workforce state-wide
- improve care and ensure that complex needs are met. Consequently the model is receiving strong emphasis in New South Wales and is being expanded to include recognition of existing skills, a defined career pathway and additional support such as a flexible training program that is aligned to job and service requirements<sup>9</sup>.

The *hospitalist*:

- is a generalist medical practitioner (Career Medical Officer) employed within hospitals, whose principal focus is provision of quality clinical care to patients in hospitals to ensure the patient journey is coordinate and as effective, efficient and as safe as possible<sup>10</sup>.
- is not in a specialist training position or working towards Fellowship of Specialist Medical Colleges.

The hospitalist skills program is available to all non-specialist doctors working in the New South Wales health system and provides an additional career development stream that fits between General Practice and other specialist training. The development and delivery of training is coordinated by the New South Wales Institute of Medical Education and Training (IMET). Training modules are offered in emergency medicine, mental health, aged care, surgery, obstetrics and gynaecology, paediatrics and general medicine. The training program is also designed with a future goal of permitting transfer between training streams through recognition of competencies attained in other training pathways, including GP registrars and GP VMOs<sup>11</sup>.

##### Rural Preferential Recruitment (RPR) program

New South Wales also has the Rural Preferential Recruitment (RPR) program that links graduates with an interest in rural medicine with suitable rural hospitals<sup>12</sup> to encourage rural based pre-vocational training. RPR requires at

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<sup>9</sup> Developing the Hospitalist Career Pathway in NSW Health. David Dixon, A/Director, Workforce Development and Leadership, NSW Health Department. Seminar presentation. Australian College of Health Service Executives. 1 July 2008

<sup>10</sup> Final Report of the Special Commission of Inquiry. Acute Care Services in NSW Hospitals. Peter Garling SC. 27 November 2008. Volume 1. p.190.

<sup>11</sup> Developing the Hospitalist Career Pathway in NSW Health. David Dixon, A/Director, Workforce Development and Leadership, NSW Health Department. Seminar presentation. Australian College of Health Service Executives. 1 July 2008

<sup>12</sup> NSW Government Minister for Health (2009) Press Release 20 January 2009: Minister welcomes more rural doctors. [www.health.nsw.gov.au/news/2009/20090120\\_02.html](http://www.health.nsw.gov.au/news/2009/20090120_02.html) (Accessed 26/05/10).

least 3 of the 5 training terms to be completed in a rural hospital (depending on the accredited status of that hospital and the remaining 2 terms are undertaken in other hospitals). Selection is merit-based and this program has expanded since its inception to currently include 12 hospitals and approximately 50 doctors. New South Wales also offers 2 year employment contracts so graduates can choose to remain in the same location for their vocational training. If they choose General Practice they can follow the GPPTP pathway, and gain additional support from the various Commonwealth programs available. The Rural Preferential Recruitment Program is oversubscribed with applicants, but the GPPTP is not.

It was reported that recent Commonwealth initiatives in Primary Health Care may have a significant impact on current primary care workforce programs and outcomes in New South Wales.

### **7.1.2 Details of GPPTP training programs**

GPPTP training is specifically aligned with area workforce needs as assessed by the Area Health Service(AHS). The program aims to attract doctors who have a commitment to rural practice and applications require their declaration to this. GPPTP is popular with doctors that have not trained in Rural Clinical Schools (RCS) and it does not give priority to RCS-trained students over other university graduates. The training cohort is quite competitive, and there is a merit-based selection process. The New South Wales Rural Doctor Network (RDN) program administers New South Wales programs providing incentives for general practitioners in country areas<sup>13</sup>. RDN also receives funding to run annual workshops on these programs.

GPPTP training posts are for 6-12 months duration, and link to existing accreditation processes for an Advanced Rural Skills Post through ACRRM and/or RACGP and curricula developed by the relevant Joint Consultative Committees<sup>14</sup>.

Trainees are assessed by Supervisors against the relevant requirements of the Specialist College. Participants do not generally require additional mentoring or support, however the RTP has a Medical Educator to whom the trainees can turn if required. Where there is an individualised learning plan there is much greater interaction between the trainee and the RTP.

### **7.1.3 Stakeholders and relationships**

When the GPPTP program was first set up, it aimed to use the ACRRM curriculum. It was reported to the reviewers that the Royal Australian College of Surgeons (RACS) had been uncomfortable with GP procedural training for surgery<sup>15</sup>, was not supportive of that curriculum and believed it is more appropriate to transport patients to surgical services rather than attempt to provide these locally. However those issues have apparently been resolved and training of GP proceduralists in surgery (mainly endoscopic) is now to a RACS certified standard.

There are some differences in views on workforce strategy between New South Wales Health and the Rural Doctors Association; for example in relation to the role of nurse practitioners; how to achieve workforce development objectives with a State-wide rather than solely rural focus; and how to meet the proceduralist curriculum outcomes required (e.g. in emergency obstetrics) which might require GPPTP registrars to spend time in other hospitals in order to meet their training hour requirements.

The support of local doctors is also important to the success of the GPPTP trainees, as they support the trainee through the program. It was reported to the reviewers that where there are supportive local doctors, training outcomes are enhanced.

### **7.1.4 Resourcing of the GPPTP**

The base salary of GPPTP trainees is fully funded according to the appropriate medical officer award for up to 12 months (Full Time) to undertake training in rural hospital locations. Training is in 5 specialties: Anaesthetics,

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<sup>13</sup> NSW Health. Initiatives & Incentives.

[www.health.nsw.gov.au/countrycareers/why\\_go\\_rural/incentives.asp#\\_Other\\_Rural\\_Incentives](http://www.health.nsw.gov.au/countrycareers/why_go_rural/incentives.asp#_Other_Rural_Incentives) (Accessed 26/05/10)

<sup>14</sup> North Coast GP Training. General Practice Procedural Training Program (GPPTP) Information Sheet.

[www.ncgpt.org.au](http://www.ncgpt.org.au) (Accessed 26/05/10)

<sup>15</sup> See for example Final Report of the Special Commission of Inquiry. Acute Care Services in NSW Hospitals. Peter Garling SC. 27 November 2008. Volume 1 pp. 204-5

Emergency Medicine, Obstetrics, Surgery and Mental Health<sup>16</sup>. Positions are supernumerary and the allocated funds are quarantined for the GP training post<sup>17</sup>. There is no bonding of registrars.

The Area Health Service (AHS) employs the trainee and is reimbursed by New South Wales Health. In addition to the salary, funds (up to \$5,000 per annum per 1.0 FTE<sup>18</sup>) are provided to support the education, training and supervision via agreement between the GP, the RTP and the local hospital. Training posts are intended to be flexible, and some allow part time options to meet training needs<sup>19</sup>.

Funding for the GPPTP is held centrally and provided to RTPs and local AHS's on individual application, usually to the RTP who puts together the information required according to defined criteria. New South Wales Health also funds the RTP to administer the program.

Registrars in this program are insured through their employment contract with the AHS with each contract specifying under which scheme they are covered.

In order to complete the training requirements, practising GPs have to obtain release from their practice for 6-12 months (depending on the training focus) and in rural locations this can be difficult. Practising GPs may feel there is insufficient funding to cover locum relief in their practice to attend the educational requirements of the GPPTP and New South Wales Health has sometimes provided additional funding to the AHS to assist with roster relief on a case-by-case basis, but this is an exception rather than the rule.

### 7.1.5 Training outcomes of the GPPTP

Intakes per procedural specialty for the GPPTP from 2003-2010 are as follows:

|                    |    |
|--------------------|----|
| Anaesthetics       | 52 |
| Emergency Medicine | 91 |
| Obstetrics         | 58 |
| Surgery            | 10 |
| Mental Health      | 37 |

In total over this period there have been 253 participants in GPPTP however the Department counts participants in each specialty, so some may be counted twice.

There is currently no demographic data available on participants. Anecdotally more males than females participate, with more females in part time places, but it is expected that with the forthcoming RANZCOG change to the obstetrics curriculum there will be more female trainees.

Similarly there is no data at this time on the medical school origin of trainees but it is believed the majority are from New South Wales, but this has not yet been analysed.

In relation to International Medical Graduates (IMGs), GPs in Area of Need (AON) categories are encouraged to undertake this program, however it can be difficult for them to secure the leave required to attend training under their practice or visa sponsor requirements. There is also an expectation from the Joint Consultative Committee (JCC) that IMG's would have already enrolled for Fellowship of ACRRM or RACGP, so they would be

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<sup>16</sup> NSW Health. Initiatives & Incentives.

[www.health.nsw.gov.au/countrycareers/why\\_go\\_rural/incentives.asp#\\_Other\\_Rural\\_Incentives](http://www.health.nsw.gov.au/countrycareers/why_go_rural/incentives.asp#_Other_Rural_Incentives) (Accessed 26/05/10)

<sup>17</sup> North Coast GP Training. General Practice Procedural Training Program (GPPTP) Information Sheet.

[www.ncgpt.org.au](http://www.ncgpt.org.au) (Accessed 26/05/10)

<sup>18</sup> North Coast GP Training. General Practice Procedural Training Program (GPPTP) Information Sheet.

[www.ncgpt.org.au](http://www.ncgpt.org.au) (Accessed 26/05/10)

<sup>19</sup> North Coast GP Training. General Practice Procedural Training Program (GPPTP) Information Sheet.

[www.ncgpt.org.au](http://www.ncgpt.org.au) (Accessed 26/05/10)

undertaking the training required for that. However if they can make all the arrangements they can be accepted into the GPPTP.

There is no specific information available on key motivators for participation in the GPPTP and it is likely there are multiple drivers. It is thought that the business case for GPs undertaking this training and subsequently being able to practise procedural medicine is quite compelling especially where there are GP partners who develop complementary skills enabling their practice to offer a broader range of services.

The GPPTP training program outcomes are in part influenced by the effectiveness of the RTP and the AHS, and the support of local doctors. RTPs have a crucial role in ensuring the whole process works, so they are a big determinant of the success of the GPPTP. It is thought that RTPs with a good philosophical approach to rural training achieve good outcomes. Similarly, positive and supportive relationships with local GPs and specialists may be associated with positive training experiences and outcomes.

The GPPTP program has not yet been evaluated, however this is in development. Evaluation and review of the GPPTP will provide a better understanding of training and service outcomes. New South Wales Health is seeking a closer alignment between the training and AHS needs, and the retention of graduates in general practices and in rural areas. While GPPTP does require applicants to declare a commitment to rural practice and to providing GP services to rural AHS's, the program is not necessarily achieving this and anecdotal feedback suggests it may be effectively training GP Proceduralists for other states.

#### **7.1.6 Scope and currency of practice**

The main mechanism for determining scope of practice is the category of the training hospital which determines the procedures the trainees can perform. This presents challenges for some aspects of the rural training programs, for example there is constant tension around the provision of obstetrics in small hospitals, but these hospitals may not get sufficient numbers of the particular types of deliveries required for training purposes.

In relation to currency of practice, there are ongoing issues involving both training and clinical privileges. New South Wales Health is in the process of introducing some modification to its guidelines that will require procedural skills in each specialty to be maintained once training is completed, including while training in another specialty is being undertaken. It is the responsibility of the Privileging Committee of the respective hospital to assess and determine clinical privileges.

#### **7.1.7 Relevance of the QRGP model to NSW**

There would not be support for adoption of the QRGP model in New South Wales as there is a fundamental difference between the two jurisdictions; New South Wales does not employ salaried GPs in hospitals as Queensland does; nor does it remunerate training positions in the same way as Queensland. The New South Wales workforce focus is based on:

- assessment of workforce needs at area levels; and
- a strong commitment to further development of the generalist model in medicine and nursing as a key strategy to meet complex care needs state-wide, not just in rural areas.

## 7.2 Northern Territory Department of Health and Families

### 7.2.1 Context

In the Northern Territory (NT), major hospitals are sited in Darwin and Alice Springs, with smaller (20-50 bed) hospitals in Katherine, Nhulunbuy (Gove) and Tennant Creek. Generalist hospital medical services in small communities are provided through a GP VMO model, where local GPs are contracted as Visiting Medical Officers (VMOs). The exception to this VMO approach is where a GP is employed as the hospital Director of Medical Services.

Staffing shortages have worsened over time, and are more prevalent in the smaller communities, curtailing their capacity to offer services that meet local need, for example the Northern Territory is currently able to provide birthing services at Katherine and Gove, but the lack of staff prevents offering this service at Tennant Creek. The doctor vacancy rate in Aboriginal Medical Services (AMS) in the NT is currently over 50%.

### 7.2.2 Development of the Northern Territory RGP program

The Northern Territory Department of Health and Families (NTDHF) has been exploring mechanisms to attract, train and retain generalist medical staff to meet community needs, and was aware of the development of the QRGP. The NTDHF has looked at the Queensland model in detail and recognised its potential for adaptation to meet Northern Territory needs. The NTDHF considered:

- it did not have sufficient positions available to meet all the requirements of training, but it could offer some positions
- allocation to training positions would require a centralised coordination approach to place trainees disposed to the rural generalist model in appropriately supervised training positions
- remuneration would need to be sufficient to both recruit and train rural generalists, and not compete with Queensland in attracting these doctors.

It was concluded that it would be appropriate and realistic to collaborate with Queensland in accessing and adapting their RGP model to suit local Northern Territory circumstances. The proposed program will help address workforce shortages and community needs, by creating a sustainable pathway for rural generalist training and up-skilling using a similar definition of Rural Generalist as adopted in Queensland.

The NTDHF commenced negotiations with Queensland 15 months ago with a view to adopt and adapt the QRGP model to the Northern Territory environment. The Rural Generalist training pathway, together with the current Northern Territory Enterprise Bargaining Agreement (EBA) is currently being negotiated for doctors and this will also define the career pathway. A Ministerial Memorandum of Understanding (MoU) with Queensland for training collaboration with their RGP is in development.

### 7.2.3 Stakeholders and relationships

The proposed Northern Territory RGP model will articulate strategies for other workforce group. Specialist outreach services from Darwin and Alice Springs are provided to multiple small communities, and where the service at Katherine, Nhulunbuy and Tennant Creek is not large enough to support specialist models (e.g. insufficient demand or workload for the maintenance of a specialist workforce). The Northern Territory also utilises other healthcare practitioners such as rural and remote nurses who provide some GP-type services in remote areas within defined treatment protocols.

The Northern Territory RGP will focus on obstetrics and anaesthetics (the area of predominant need) and will continue to offer an Indigenous health option (as is currently available). The program is likely to also support broader workforce developments such as the move to community birthing which will see an increased role for midwives.

The NTDHF is also monitoring the development of other models such as the Queensland Physician Assistant program, but is mindful of resistance within some medical groups in the Northern Territory to these initiatives.

It is intended by NTDHF that Rural Clinical Schools (RCS) will be closely linked with the proposed rural generalist program as many clinicians currently have dual roles of service provision in hospitals and teaching at RCS's, and have salary components paid by both.

NTDHF and the South Australia Flinders Medical School are collaborating on the development of a new medical graduate program with rural generalist pathway entry points available in the final year of medical school; at PGY 1&2; and for existing medical officers. Depending on the outcomes of the EBA under negotiation, additional support offered to these trainees may incorporate a bonding scheme for students at completion.

#### **7.2.4 Resourcing**

All RGP trainees will be employed by NTDHF as salaried Medical Officers during their training. The resourcing of additional training will be guided by the requirements of the body that awards the higher qualification. As is currently the case, NTDHF will continue to support trainees who have interstate training requirements.

Currently all trainees receive a professional training allowance. It is anticipated that within 2 years all RGP training will be completed in the Northern Territory rural sites. This may necessitate additional site-specific infrastructure resourcing.

There is no current decision on bonding of trainees – this will depend on the EBA to be negotiated. If the EBA does not include a RoS obligation, NTDHF hopes to be able to offer an adequate remuneration package that will encourage retention of graduates to practice in the NT.

Insurance is covered by the employing institution in the first instance but NTDHF advises all medical employees to also carry their own insurance to cover legal representation and the Medical Registration Board also requires doctors to be indemnified.

The NTDHF offers a standard package of incentives such as locum relief for all employees (nursing, medical etc) and the RGP terms are not expected to differ greatly from current incentives. Locum relief also needs will be reviewed as it depends on adequate staffing numbers to be effective.

The Northern Territory RGP program is expected to become fully operational in 2011. There is currently one trainee in place at Katherine, and 3-4 prospective candidates have expressed interest in commencing in 2011. Advertisements in the national press in the next two weeks will call for expressions of interest, followed by interview and job offers. Entry points for trainees and the training pathway itself will parallel those in Queensland.

In implementing the program NTDHF will need to remain sensitive to the QRGP arrangements for its trainees, and not compete with these to the detriment of either program.

#### **7.2.5 Scope and currency of practice**

Scope of practice relates to both the practitioner and the facility in which they practice. NTDHF consideration are listed below.

- NTDHF is currently developing credentialing strategies for all medical staff which will apply across the whole Territory and it is expected that scope of practice issues will be defined within the next 12 months. At present the main constraint is the need to negotiate the EBA, although this is expected to be concluded and approved by next year. NTDHF is maintaining a watching brief on Queensland developments in relation to scope of practice approaches.
- Standards of training will be based on the national framework for PGY 1&2 doctor training and the respective College requirements. The Northern Territory also has its own requirements within hospitals to ensure satisfactory performance. It is expected that RGP trainees will also concurrently enrol in Fellowship training for ACRRM or RACGP.
- The individual sequence of training will be negotiated. Some Colleges require a two stage process for advanced skills e.g. to achieve the RANZCOG Advanced Diploma trainees are required to complete the basic Diploma first and then be assessed for capacity and skill level to undertake the Advanced Skills course.
- Maintaining currency of practice post-training is important, especially in isolated work environments. The NTDHF currently supports doctors to attend Darwin on a regular basis (2 weeks each 6 months) to be reaccredited (e.g. in Anaesthetics or Obstetrics) and alternatively sends obstetricians out to Nhulunbuy to reaccredit doctors.
- Normal teaching and service commitments will be expected of RGP trainees.



### **7.2.6 Further developments**

Training places are currently limited by case throughput, and there is some competition for training places (eg obstetrics in Darwin), so can only manage 1-2 trainees (over all disciplines) per year. This is where the benefit of the MoU with Queensland will be realised.

If applicants are unsuccessful in entering the RGP program initially, it is hoped that the guarantee of future employment may attract re-application for entry in years subsequent to PGY2 or above.

### **7.2.7 Outcomes for trainees**

Most graduates of the RGP will emerge with Fellowship of ACRRM or RACGP (as in Queensland) plus additional qualification such as the Advanced Diploma of Obstetrics and Gynaecology (DRANZCOG Advanced) or the JCCA Anaesthetics or the ACRRM Emergency Medicine module. There are currently no advanced qualifications available in other specialty areas. If graduates attain Fellowship with these advanced skills they will be transferable across Northern Territory facilities. However where the graduate does not hold FACCRM or FRACGP this may affect their transferability.

Those who choose not to complete the College Fellowships can be employed as Medical Officers and have appropriate recognition for their advanced skills.

### **7.2.8 Outcomes for services**

Over time it is hoped the program will produce sufficient Rural Generalists to meet Northern Territory service needs. It will contribute to meeting the GP requirements of Northern Territory towns, support local hospital VMO needs and complement the traditional model of general practice.

Greater integration with AMS services is also a potential outcome. Currently there is one example where the RG trainee (with accreditation in anaesthetics) located in Katherine provides one day per month in the AMS, and another person going to Nhulunbuy.

### **7.2.8 Relevance of the QRGP model to the NT**

The NTDHF is working closely with Queensland Health to implement the QRGP model in the Northern Territory in 2011. Key strategies include the development and centralised allocation of training positions, the development of a new EBA and a Ministerial MoU for training collaboration between the two jurisdictions. The definition of rural generalist will be similar to that adopted in Queensland.

## 7.3 South Australian Department of Health

### 7.3.1 Context

South Australian rural health facilities operate on a VMO model, with 430 GPs across South Australia receiving a fee for service to provide emergency department (ED) and procedural services. The fee for service agreement includes provision for an on-call allowance which is negotiated with the particular GP practice which will fill the roster. The VMO fee for service model is also networked with specialists who provide visiting services.

There is also significant coordination for some support facilities, for example in cardiology where there is 24/7 cover and backup for rural complex cases; and in maternity services. There is ongoing exploration about similar arrangements with other specialties, however historically, this support is relationship-generated, rather than through formal coordination. There is only a limited number of resident specialists in some of the larger towns, for example there are no psychiatrists resident in rural South Australia, all are located in Adelaide.

### 7.3.2 Details of RGP training

Rural general practice trainees In South Australia progress through one of two Regional Training Providers (RTP). Most of the training happens in central Adelaide where they complete their hospital training. Those who choose the rural pathway are rotated out into general practices, some of which provide emergency department coverage, however South Australia does not have large regional areas with dedicated hospital facilities like Queensland. There are some small rural clinical schools which oversee some trainees while they are in the more advanced GP training centres. As far as the South Australian Department is concerned, the RTPs run the general practice training program.

South Australia has problems in obtaining Advanced Skills Training posts for rural trainees, which the RTPs negotiate with the large teaching hospitals. Trainees tend to come back to Adelaide in the fourth year of their training. It is a fairly idiosyncratic, individualised, and personality dependent approach. The hospital based specialty training programs tend to preferentially allocate posts to their specialist trainees, especially where there is an excess of applicants for training, because they need to service the specialist requirements of their hospital, for example, in emergency departments, anaesthetics and surgery.

Quarantining of training positions for rural trainees has not been addressed because the volume of generalist trainees is not large, numbers vary from year to year, and the hospitals cannot always get sufficient rural trainees to fill the posts.

### 7.3.3 Outcomes for trainees

There is only a small number of trainees entering the rural training pathway, but the South Australian Department does not know the exact numbers since it has traditionally not engaged in training for general practice. It is left to the individual trainee and the RTP to manage and organise placements for the advanced skills training component. The Department is of the view that generally the numbers are low and the organisation of placements is individualised.

Based on feedback it has received, the South Australian Department is satisfied with RTP quality and outcomes.

Under its current arrangements, the South Australian Department does not know what the retention rates are for pre-vocational trainees. About 30% are thought to remain in rural general practice on completion of the 12 month Flinders University Parallel Rural Community Curriculum (PRCC)<sup>20</sup> program, but this is no different to retention rates for all other GP trainees.

### 7.3.4 Further developments

Future developments in South Australia include an expansion through the *Extended Settings Training Program* for certain specialist trainees to go out into the country. This is a Commonwealth funded initiative intended to increase the number of training posts and the supervisor pool, for example in surgery where there are now surgical trainees in a number of rural surgical sites. There are also a number of other trainees and training positions in other rural sites.

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<sup>20</sup> The PRCC is a 12 month pilot of undergraduates training in rural locations, for rurally motivated students. It is not a 3 year training program as described by Stagg, Greenhill & Worley, 2009

There are 4 larger rural sites which will be the focus of the South Australian Department's *Strategic Plan for 'Rural Centres' for Care*. Some trainees are already going out to these centres. Once these rural centres have the increased capacity and infrastructure, and there is more supervisory capacity, this will increase the training capacity as well. Other *ad hoc* arrangements apply where rural trainees go out with specialists, but this is very individual.

The current training structure is difficult to sustain. It is a "bottom-up structure" where interns need supervision, often come from registrars, who themselves need supervision. The new "top down" structure of the 'Rural Centres' will address this issue.

### **7.3.5 Stakeholders and relationships**

South Australia is leading the country with Physician Assistant (PA) pilot development and a decision about them is due on 29 June 2010. The PA pilot has a Steering Committee that will provide advice to the Minister on the applicability of the PA role in SA. Without pre-empting any outcome the South Australian Department considers the PA pilot (which has been running for about 18 months in SA) is going well and the feedback has been positive.

In relation to Nurse Practitioners, the South Australian Department has additional funding to support them and sees these roles as complementary, not only in rural but also in metropolitan settings as well. It is expected this program will expand within the next 2 years.

There are two Rural Clinical Schools (RCS) in SA. The first is the combined University of Adelaide and University of South Australia RCS in the Upper Spencer Gulf and Flinders University RCS based in the Riverland (Berry and Mt Gambier) with a combined placement in the Barossa Valley, and linking into the Southern Fleurieu Peninsula. The latter RCS has an outer metropolitan and inner rural locus and also has links to the Northern Territory in Alice Springs. The Rural Clinical Schools are not formally tied into the South Australia general practice training programs. Their link is usually through GP practitioners having training roles in the RCS and their focus on medical students.

### **7.3.6 Outcomes for services**

The South Australian Department sees the Rural Generalist model as an innovative and positive way to look at workforce, not just in rural areas where there is the primary need, but also in metropolitan areas. There has been an evolution of skill bases that has often become vexed (through the narrower focus of each specialisation) creating problems in caring for people with multiple clinical conditions.

It was reported to the reviewers that having people with generalist skills, who can assess, manage and treat, may assist in addressing a number of workforce issues including burnout. For example in Emergency Departments (ED), there are significant constraints imposed by the current level of demand, there is little opportunity for further professional development, and there are high levels of discontent. The opportunity (through a program such as RGP) to access relevant training and credentialing and broaden the skill base to work in other areas is important to both ED's and the consultants, especially in country areas where it is not possible to engage a number of the large subspecialties.

### **7.3.7 Scope and currency of practice**

The new South Australian Health Credentialing and Scope of Practice Policy requires graduates to maintain and complete a recognised CPD program. The South Australian Department will be undertaking an initial evaluation of this policy in the immediate future.

The South Australian Department identified the following issues to be addressed in relation to scope and currency of practice.

- The RGP is a formal structured curriculum and training program culminating in appropriate credentials which should help with the employment processes that are now much more rigorous in relation to credentialing and defining scope of practice according to skill base.
- The RGP model has great potential to address both rural and non-rural workforce issues.
- The RGP encourages formal inter-college cooperation and collaboration - Colleges have traditionally been separate from one another but this model will help to form links between them, for example ACEM and the College of Physicians are currently exploring joint training opportunities.

- The training program must not create a trainee who is outside the College specialist system but must be congruent with the Colleges and their Fellowships.
- The RGP model presents an opportunity to define the types of skills needed for rural practice, and define the employment model that fits. This would not be specifically Fellowship-dependent, but skills-dependent. The current College system does not adequately address the complex skills-mix needs in rural areas. Under the current systems the trainees have to enroll with a particular College's training program and it is not possible to do two Fellowships, unless it is a formal joint training program with a description that is "owned" by each College. Further, trainees can only become registered as a specialist through achieving Fellowship of a relevant College. This will remain the case under the new Medical Board arrangements.
- What is needed in rural areas is a certain set of skills and while these might be achieved via multiple Fellowships, they might also be achieved without completion of any Fellowship at all.

The GP training program is principally located within the private sector, through GPET and RTPs who function within a private model. This private sector training is coupled into some public facilities throughout the country. It requires a degree of effort to bring both together. It was reported to the reviewers that it is important to ensure that the training model is not forcing a public system on a private one, and conversely, to make sure that the private system addresses the quality assurance that public systems have.

- Where "ownership" of the advanced training program is more affiliated with a particular College rather than with the employing agency, there may be some differences in allegiance that may cloud the health priorities.
- The need to avoid a conflict of interest by ensuring that the examiner, supervisor and employer are not all the same person. South Australia IMET was established as a link between the employer and the Colleges to ensure the trainees get the training required, not just fulfill a workforce role.
- The opportunity for joint training programs is grossly underexplored. In the current registration processes, to be on a specialist register it is necessary to have completed Fellowship training. But training in Emergency Medicine, for example, does not necessarily provide skills in in-patient care. Training modules that are recognised and shared between Colleges may be a better way of achieving the broad skill base needed in rural settings and they might be offered independently of Fellowship.
- Recognition of Prior Learning is College-specific (and varies between Colleges).

### **7.3.8 Resourcing**

In South Australia there are no bonding or RoS obligations on trainees.

Insurance is a personal responsibility of trainees (they are not employees of the South Australian Department, so any insurance including Workers Compensation insurance is their responsibility). Where they do complete their first year or their AST in hospitals, they are covered by the State.

There are a lot of IMGs in the South Australia rural training program, and working in rural general practice. IMG's would benefit from support such as that available within the QRGP (as long as it was appropriately resourced).

### **7.3.9 Relevance of the QRGP model to SA**

Rural GP training in South Australia is primarily the responsibility of Regional Training Providers and this is unlikely to change in the near future.

The South Australian Department sees the QRGP model as innovative and having the potential to address a number of barriers to current programs, especially in improved coordination of training programs across training providers and Colleges.

There is support for a "generalist" medical role across all geographic sectors including metropolitan areas.

## 7.4 Tasmanian Department of Health and Human Services

### 7.4.1 Context

The nature of Tasmanian rural practice is different from other jurisdictions, including its employment of rural doctors. Tasmania has 15 small rural facilities of varying sizes from 2 beds attached to aged care facilities up to 20 beds. No facility is more than 1.5 to 2 hours from one of the base hospitals. This means that the isolation factor is not as great as some other jurisdictions. There is no need for rural generalists because it is regarded as medico-legally inappropriate if there is a base hospital that can provide the appropriate services

Tasmania contracts a small amount of local GP time, and in some cases corporate medical providers, to provide inpatient care in small facilities. GPs are paid on an hourly rate, according to the number of beds and the acuity of the hospital. The award was renegotiated last year with a 50-70% improvement on prior award rates. These doctors are not urban GPs but they are not procedural GPs either. Procedural work varies, depending on the capacity of the facility including workforce skills. For example, one small facility still does obstetrics; another previously provided obstetrics but there were insufficient rural nurses with obstetrics qualifications to allow deliveries to continue.

Emergency medicine is an issue especially in the island locations such as Bass Strait and King Island. Emergency medicine skills are required approximately 3 to 5 times per year. "Tier one facilities" such as the Bass Strait Islands and those over two hours away from base hospitals require their doctors and locums to maintain emergency skills through the credentialing process; they are required to have Emergency Life Support (ELS) and Advanced Life Support (ALS) training. Currency of practice is maintained through emergency up skilling programs run by professional Colleges such as ACEM, ANZCA and ACCRM. The courses are available locally in Tasmania but not run through the Department of Health and Human Services

### 7.4.2 The RGP model

Tasmania has not had the need to embrace such a strong rural philosophy as other jurisdictions, as it has three major hospitals serving a decentralised population of 500,000 distributed in each corner of the State, with two thirds of people living outside of Hobart.

The generalist practitioner is likely to be of most use in places such as the North West coast because trends suggest it will become harder to attract specialist consultants to the area. The North West region has about 1/3 of the population of Tasmania (about 120,000 people) and it currently has difficulty attracting specialists, resulting in workforce deficiencies due to volume and on-call arrangements. The region is not yet exploring the generalist model but may eventually do so.

Locally independent Area Health Services are likely to continue to try to attract and maintain specialist workforces.

### 7.4.3 Resourcing

Tasmania has a salaried medical officer structure for specialists who are consultants in the three major hospitals and the Mersey Hospital. No salaried medical practitioners are working in the rural facilities. Career Medical Officer awards and training structures like New South Wales are likely to develop as the new generation of doctors don't necessarily want to fit into old models, commit resources to private practices or join in groups of practices. Currently there is no emerging cohort of young career medical officers: they are generally either specialist consultants or doctors in training.

### 7.4.4 Future developments

Tasmania is currently building two large integrated care centres – the service model for which has not yet been fully determined – and there may be positions that emerge there for generalist medical officers.

Launceston General Hospital is concentrating on becoming more of a general physician/generalist hospital though it still has orthopaedics and all of the major specialties except neurosurgery, creating a place for the well trained generalist into the future.

### 7.4.5 Stakeholders and relationships

Nurse Practitioners are already working in specialist areas: mental health, renal and aged care but there are no rural nurse practitioners although there are several outposts including a couple of smaller islands and isolated

places where nurse practitioners could flourish, however legislation (e.g. Drugs and Poisons Act) has been a barrier.

#### **7.4.6 Outcomes for services**

Tasmania has been relatively fortunate in being able to recruit GPs and there is no town of any size that does not have its quota of GPs. This is partly due to the employment of a company about 10 years ago (previously Gemini, now part of Independent Practitioner Network) who specialise in supplying rural GPs on contract. This has worked by paying a small premium to maintain continuous medical cover in all small towns. Many of these have been IMGs. For the last 7 years there has been a program of interviewing the IMGs (now introduced in all States) using the PESCI (pre-employment structured clinical interview). Interviews have rejected about 50% of the IMGs because they were not clinically suitable.

#### **7.4.7 Relevance of the QRGP model to Tasmania**

Tasmania does not use rural GPs with procedural skills in its facilities due to their proximity to hospital centres where procedural services are available. The QRGP model is therefore not applicable in the State. "Generalist" medical officer roles within hospitals are seen as a potential development in the future to address specialist shortages and continuity of care between hospital and community settings.

## 7.5 Western Australia Department of Health

### 7.5.1 Context

In 2006, Western Australia Country Health Service (WACHS) and Rural Health West (RHW) undertook a consultancy with the State's rural doctors about how Western Australia could develop its rural workforce to provide the services needed into the future. The consultancy talked to all rural doctors at the time; about 300 doctors participated. One major recommendation was that Western Australia develop its own rural generalist pathway.

In 2007 RHW obtained a small fund from the Health Department to scope out a rural general pathway in Western Australia. Western Australia Country Health Service (WACHS), RHW (the Western Australia Rural Workforce Agency), RACGP, ACRRM, the Post Graduate Medical Council (AGMEC), GP networks, the Rural Doctors Association, AMA, junior doctors, and all other stakeholders thought to have an interest in this program, shared views on what such a program could look like. Input was also provided from Queensland Health on the QRGP model – which at that time was in its first year. WACHS reviewed the Queensland processes and how they had developed their RGP model.

The consensus in Western Australia was that the QRGP model was not suitable because Western Australia does not have large rural hospitals. The largest rural centre in Western Australia is in Bunbury (population around 50,000 including the surrounding areas). Bunbury does not have a fully salaried serviced hospital – it relies heavily on Visiting Medical Practitioners (VMP) for specialist services such as paediatrics and surgery. It is hard to provide much training, although there is some occurring. However in small hospitals with populations of 20,000 there will often be only one specialist and mainly VMP's supporting the hospital.

The reviewers were informed that WACHS thought Western Australia needed a model that looked at using both hospital and community placements and also getting procedural training back in the larger centres such as Bunbury and Perth. This would mean having to work very closely with the Perth teaching hospitals for the procedural training places.

### 7.5.2 Development of the RGP program

In 2009 WACHS presented a business case to government for the RGP in Western Australia. The initial business case was expansive, proposing that WACHS should become a Primary Allocation Centre, responsible for placing 30 doctors in country areas from start to finish, with mainly rural training places augmented by buying city-based skills training places. This business case was not funded.

A modification then pared the program back to 25 Junior Doctors; working closely with Western Australia GPET, the Rural Clinical School (RCS) and the Community Residencies Program in Western Australia (how Prevocational General Practice Placement Program is run by Western Australia GPET). WACHS now have a program which is aiming for 30 intern positions placed throughout all the rural hospitals in Western Australia. It will also include around 30 PGY2, and 8 to 9 PGY3 trainees.

The aim of the WACHS RGP model is that once trainees have completed their PGY3, they will exit to a College training program, whether ACRRM, RACGP or another specialist College.

### 7.5.3 Future developments

Future developments will depend on the success of the program, and a clear commitment from the Department in terms of the rural generalist pathway as part of the broader system for the entire state. WACHS still prefers being the Primary Allocation Centre, and this remains on its agenda for 2012. The development of the Western Australia RGP model is thus seen as an incremental process rather than the more expansive model originally outlined.

WACHS is working with WAGPET but at this time has not embarked on the broad education program of Queensland, and WACHS has not developed a specific descriptor of 'The Rural Generalist Pathway'. WACHS indicated that trainees can do their rural generalist training through ACRRM or RACGP, and WACHS will provide the PGY1 – 3 training if this is needed prior to entering the College's program. WACHS is also trying to support the 'generalist specialist' position because there are significant workforce issues, and WACHS also recognises that even though general practice is becoming more popular, there are a lot of junior doctors who want to specialise but who will not go into the country.

#### 7.5.4 Stakeholders and relationships

There are some challenges in separating the respective roles of RCS and the RTP in WA and how they collaborate:

- the PGPPP program in Western Australia is jointly run by RCS and the RTP, and given the WACHS RGP program is still very much in a developmental stage, there are some issues to be clarified including the curriculum
- RCS and WAGPET both have facilities in the country so one challenge is which to use
- WACHS wants to work with RCS and the RTP because there are limited teachers in the country, and often in a site the RCS teacher is also the WA GPET teacher
- WACHS wants RCS and the RTP to be involved in the junior doctor training. A question is which agency should do this – WA GPET or RCS, or does WACHS itself need to come in, effectively making 3 employers for the trainee. This issue has not yet been resolved.

The specialist medical Colleges – and getting access to specialist skills training, remain a challenge. Although there is some obstetric training in the country there is only 1 anaesthetic training place in country WA, and while WACHS would like to do more in the country, Western Australia is still reliant on the city placements. Some of the ANZCA ‘preconditions’ for training posts (such as the need to have 2 anaesthetists, or certain other specialists on hand) make it more difficult to achieve these training posts in rural areas.

A broader issue that WACHS is also confronting relates to supervision, training and the VMP system of providing health services. This includes the impact of IMGs in delivering the rural generalist pathway. Realistically there are country towns where there is no doctor, and these small towns still expect a health service, so there is a central need to managing this service demand as well as providing training for junior doctors in relation to the longer term sustainable workforce. This means it is not possible to view a particular rural setting in isolation, it has to be part of education and training overall. The issue for WACHS is getting well trained doctors who are comfortable working in small rural areas; that have the skills in the areas of need and that are supported.

The VMP system has changed somewhat over the past 2-3 years since WACHS started the RGP program. Originally most of the hospitals were reliant on VMPs to provide most of the afterhours services, now all of the regional resource centres have salaried staff – but not necessarily specialists. WACHS sees an important need for generalist specialists and the development of a rural generalist model. Western Australia does not have the workforce or population base to support their specialist services in country areas.

In addition to accommodation, travel and support, WACHS sees a need for flexibility in training and supervision and making sure trainees and supervisors have appropriate support and training. The rural generalist is perceived as very important to the future of rural Australia in general and in Western Australia in particular:

- Western Australia has relied on IMGs for many years; currently about 52% of the rural workforce come from overseas
- there has only been one medical school in Western Australia and the number of graduates has not increased in 20 years
- the IMG intake into country Western Australia has dropped by 80% since the new national assessment process has come on board
- the Western Australia workforce is losing doctors at a great rate from small country towns.

#### 7.5.5 Resourcing

WACHS has been wrestling with a lack of funding and support, especially for some of the procedural training posts. WACHS have secured \$8.5 million of Government funding via the *Royalties for Regions* initiative - to help support the program. This will support accommodation, travel and some additional support for doctors in rural places, but as yet there is nothing specific for salaries, wages or education.

Resourcing for VMP providing the training also needs to be provided.



### **7.5.6 Training program details**

The Western Australian model has developed slowly, with a Working Group comprising the Rural Clinical School, WAGPET, Post Graduate Medical Council, Junior Doctors, RHW and WACHS continuing to meet regularly for the past 2 years. The Working Group has developed the model where Western Australia can sustain interns, PGY1-3 and look at some rural procedural training places.

The current QRGP has 23 intern positions in the 6 major regional centres; and 27 PGY2 and PGY3 in small regional hospitals; and about 20 pre-vocational general practice placements in rural Western Australia. The Western Australian RGP model provides the PGY1-3 experiences for trainees who then exit to the specialist training programs of either ACRRM or RACGP. Medical students can enter for their PGY1 (first year of prevocational training) and other eligible doctors in their second (PGY2) year. From PGY2 trainees undertake core training in Emergency Medicine and Paediatrics; in PGY3 they commence basic training in Obstetrics and Anaesthetics and Aboriginal Health. From PGY4 trainees can apply for the Advanced Skills Program (to the two GP Colleges).

PGY 4 general practice trainees will enroll in the WAGPET training program and WACHS works with WAGPET to get them into their rural training places. The general practice or AMS in which they are placed pay their salary. There are some community residency doctors who are paid by WACHS, once they get into a training program. WAGPET also has some training funds for Aboriginal posts once trainees are accepted into the training program.

The QRGP salary would be a huge disincentive in Western Australia; WACHS does not yet have the PGY4 places because it is not yet funded for this. The exception is Kimberley, where a PGY4 trainee who has completed advanced skills in anaesthetics, is employed on a full time basis, and receives support for other training.

Hospital training posts for the procedural training are predominantly in the Perth hospitals.

The three Primary Allocation Centres in Perth are linked to the rural placements. All final year undergraduate medical students apply to one of these hospitals, and then the hospital allocates the rotations: Fremantle Hospital does rotations to Albany and Broome; Royal Perth Hospital to Bunbury, Kalgoorlie and Port Hedland; and Sir Charles Gardiner Hospital to Geraldton and Port Hedland, but this may change in the near future.

### **7.5.7 Outcomes for trainees**

There is some resistance from the Primary Allocation Centres, with rural locations feeling they are not ready for this development, and do not have the support and training structures in place to provide this independently. In addition, the junior doctors were concerned that they may be disadvantaged if they undertook all their training in rural areas, then subsequently decided to do a specialty; they would not be in the networks of the Colleges.

Other issues include perceptions that it is not good for doctors to be placed in country areas where they cannot get all the experience they need although the Rural Clinical School has proved that medical students that go out into the country do just as well as those who stay in the city. WACHS recognises there are particular pre-requisites e.g. accommodation and travel that are needed in the country areas and that these are not necessarily needed in the metropolitan areas.

Another issue for WACHS is that all the Interns in Perth do five rotations, all of which are accredited by PGMEC, and have to do 6 months medicine and 6 months surgery. WACHS is only allowed to have a maximum of three rotations in country areas, and then have to match these back to city rotations. There has been a lack of acceptance that in a general hospital such as Albany or Bunbury, there is extensive exposure to a wide range of cases.

### **7.5.8 Outcomes for services**

This is the early days for the Western Australia RGP program, in fact too early to predict the ultimate practice destination of the trainees,. However WACHS thinks based on trainee feedback to date, they will be mainly in general practice and Aboriginal health. WACHS have a number of trainees in the Kimberley who are expressing their enthusiasm, but given this cohort is in its first year, WACHS is not in a position to determine outcomes yet.

### **7.5.8 Relevance of the QRGP model to WA**

Western Australia is developing its own version of the Rural Generalist Pathway model following extensive stakeholder consultation and program development. The QRGP model was considered but not adopted due to

WA not having regional hospitals networks like Queensland and the cost burden of the QRGP salary structure. Key challenges in the WA RGP include:

- building training capacity in regional locations
- addressing competitive barriers to selection and placement of rural procedural trainees in metropolitan hospitals
- coordination of relevant stakeholder effort
- ongoing funding and support for the program within a broader strategy of health workforce development in the State.

## 7.6 Department of Health, Victoria

### 7.6.1 Context

In its guidelines,<sup>21</sup> the Victorian Department of Health provides a framework for rural GP procedural practice, including surgery, obstetrics and anaesthetics. A rural or remote procedural GP, for the purposes of the guidelines is described as *'providing non-referred services, normally in a hospital theatre, maternity care setting or appropriately equipped facility, which in urban areas are typically the province of a specific referral based specialty'*.

### 7.6.2 Development of the RGP program

The guideline, which was developed in consultation with an advisory group with representation from the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practice (RACGP), the Royal Australasian College of Surgeons (RACS), rural GP proceduralists, rural directors of medical services and rural health service managers outlines:

- processes for defining the scope of clinical practice of the rural GP surgeon
- relevant requirements to be considered by rural health services when appointing a GP surgeon as a visiting medical officer (VMO)
- details of training programs, pathways and courses for rural GP surgical training.

### 7.6.3 Scope and currency of practice

An appropriate scope of clinical practice for a Rural Procedural GP is required to be defined by relevant credentialing authorities according to the following principles:

- the level of procedural work undertaken within the health service will be in accordance with the Rural procedural services planning framework
- the scope of practice will be defined according to processes outlined in the Victorian policy handbook<sup>22</sup>
- the health service committee responsible for defining the scope of clinical practice of the rural GP surgeon must have input from either a rural GP surgeon or a rural general surgeon who has no conflict of interest regarding the appointment
- the rural GP surgeon trainee must show evidence of current Fellowship with either ACRRM or RACGP
- the training post undertaken by the rural GP surgeon must be accredited by either ACRRM or RACGP
- there is evidence that the supervision of training of the rural GP surgeon is in accordance with specifications of either ACRRM or RACGP as appropriate. The supervisor should be a rural general surgeon
- the rural GP surgeon trainee will present a logbook of procedures and have assessment signed off by the supervisor
- there is evidence of completion of a training certificate signed off by ACRRM or RACGP
- the rural GP surgeon trainee must have successfully completed one or more upskilling courses, (recommended courses include EMST, APLS, CCrISP and ASSET). Evidence of upskilling must be provided every three to five years.
- there is written evidence that the rural GP surgeon participates in ongoing continuing professional development that complies with ACRRM or RACGP.

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<sup>21</sup> Department of Health Victoria (2009). Rural Procedural Services, Principles for defining the scope of clinical practice for GP surgeons. Melbourne, Department of Health Victoria.

<sup>22</sup> Credentialing and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook, 2009, Department of Health Victoria.

#### **7.6.4 Resourcing**

The Australian Department of Health and Ageing (DoHA) and the Victorian Department of Health support the training of rural GP proceduralists through funding procedural upskilling posts.

#### **7.6.5 Training program details**

The Australian Government provides funding through the Training for Rural and Remote Procedural General Practitioners Program (TRRPGPP). This provides financial assistance for procedural GPs in rural and remote areas to access relevant activities in order to assist them in maintaining or updating their skills. The program is jointly administered by ACRRM, RACGP and Medicare Australia.

The program provides funding for supernumerary advanced procedural skill training posts in areas of GP workforce shortage or for the development of new posts in service delivery priority areas. Funding is made available for trainee salaries, mentoring, accommodation and travel for posts in anaesthetics, surgery, obstetrics and emergency medicine.

The Advanced GP Procedural Posts in Rural Areas is a Victorian program that provides an avenue for undertaking advanced rural GP surgical training, either with ACRRM or RACGP. The number of surgical training posts each year is determined by the level of interest of trainees and health services. A rural GP wishing to train as a GP surgeon may undertake training either through the RACGP Advanced Rural Skills pathway or the ACRRM Advanced Specialist Training pathway.

#### **7.6.6 Relevance of the QRGP model to Victoria**

Many of the aspects of the QRGP have application to Victoria and the Department of Health, Victoria believes that its current arrangements reflect those aspects adapted for the Victorian context.

Victoria has a very different employment structure to that of Queensland and relies to a much greater extent upon general practitioner VMOs to provide procedural services in rural hospitals. Victorian rural hospitals employ staff in their own right and have contractual relationships with general practitioners who have admitting privileges. The Victorian Health Department has developed strategies around rural proceduralist training posts which provides advanced skills training over a 12 month period in emergency medicine, surgery and anaesthetics. There are currently 15 such posts funded each year in Victoria and the Department intends to increase this in future years to 30 posts. Other strategies include the development of career medical officers or 'hospitalists' on the NSW model and the development of training programs for international medical graduates. The Department has also, through the *Roads to Rural Practice* program, increased the number of rural internship places by 50%.

The Victorian Health Department is concerned that the Queensland RGP is a more expensive option than the training program as it operates in the State. Also, it is concerned to maintain the flexibility of the current employment conditions of medical officers. There is a concern that the establishment of a designated rural generalist position on the Queensland model would introduce inflexibility in the medical workforce. The Department recently funded a review of GP proceduralist positions. One outcome of that review was to identify that medical officers were being trained in advanced skills and then not having the opportunity of utilising those skills.

## 8 Stakeholder feedback on the QRG

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### 8.1 Summary of feedback from the Specialist Colleges

All Colleges recognise the misdistribution of specialists especially in rural/remote Australia. While specialist services should ideally be provided by fully trained specialists themselves, the procedural Colleges recognise that in remote areas, GPs are often relied on to fill these gaps. Consequently there is a need to address the service gap in a safe and appropriate manner by relying on input from appropriately trained GP Proceduralists but their focus needs to remain on assessment, triaging and managing relatively uncomplicated cases, and referring on the complex ones to centres that can provide the necessary backup skills and facilities. This is particularly the view of the Colleges for surgery, anaesthesia and obstetrics and gynaecology.

There are different workforce needs across the jurisdictions, reflecting the population dispersion and number and case throughput of small rural hospitals and there is a substantial rural workforce challenge in Queensland and Western Australia.

Training opportunities are similarly limited across the jurisdictions, and at least one College (ANZCA) noted there has been no matching of the multiple specialist services that are simultaneously required in a given location (surgery, obstetrics and anaesthesia).

#### 8.1.1 Demand for a rural generalist model

The procedural Specialist Colleges have for some time been engaged in teaching the specialist qualifications that are required for general practice, and in some cases (e.g. anaesthetics) there was already ad hoc training for rural general anaesthetics in Queensland but the Colleges reported that substantial effort is still required to provide appropriate procedural training and support.

In their view, the Rural Generalists/GP Proceduralists must be trained to the appropriate level of service required given the nature of the facilities and back up services available, and remain in supported networks that include fully trained specialists.

All Colleges acknowledge the alignment of the QRG with the GPET program. However, in the view of the Colleges, the 12 month AST training period for GP procedural skills, poses a particular challenge in ensuring proficiency and confidence in the right skill set needed for rural practice. There is also competition between the specialist Colleges for the same training 'space'.

Almost all Colleges are considering the interface between specialist qualifications and rural generalist roles and some trainees have sought formal certification of the procedural training components. RANZCOG offers a formally assessed, supported, and already recognised Diploma in Obstetrics and Gynaecology and Advanced Obstetrics and Gynaecology which lead to straightforward implementation in the RGP's AST stream. ACEM is pilot testing a non-specialist Certificate and is discussing its use with RACGP and ACRRM. ANZCA is considering a certificate award; it does not support the award of a Diploma given the potential for confusion with the Fellowship Diploma, and the 12 month duration of the training offered.

#### 8.1.2 Support for the rural generalist model

The Colleges of Surgery, Obstetrics and Gynaecology and Anaesthetists recognise the value of the RGP approach particularly by their involvement with RACGP and ACRRM in joint consultative committees to address GP procedural training and the recognition of appropriate set of skills recognised as necessary for rural practice and the importance of consultation prior to intervention.

RACS, ANZCA and RANZCOG were closely involved in the development of the AST components.

RACGP was also involved but has expressed concerns about the processes for the development of the RGP; lack of recognition of the role it has in relation to rural general practice and rural procedural retention; and perceived differential treatment of the endpoints of training for ACRRM and RACGP.

ACEM reported that they were not a formal participant in the consultative committees. This College emphasised that use of the publically available ACEM curriculum as the EM component of the RGP training program should not be read as its formal participation in the development of the RGP. ACEM also advised that it is not formally aware of any training course, assessment pathway, or delineated competency standards associated with the EM component.

RGP is viewed by all Colleges as principally a workforce strategy for Queensland Health, with particular recruitment and retention goals. The Specialist Colleges' stress the importance of RGP producing a workforce that is in accord with their own training programs. Colleges are anxious that it pay sufficient attention to these training needs and standards as well as service needs.

There is a view that the RGP may draw some doctors away from other specialist training because of the attractive remuneration it offers and the preferential allocation of training posts. RACGP considers that RGP potentially may have the perverse effect of taking people with an interest in rural practice and having them end up with a general practice Fellowship derived solely in a hospital system in regional centres.

The formally accredited AST programs such as DRANZCOG and the imminent ANZCA standardised examination and credentialing standards are seen as a means to minimise variability of standards across trainees and training locations.

The generous remuneration package of the QRGP is seen by the Colleges as a significant factor in its early successes in recruiting trainees. The same package presents a competitive disadvantage for those other trainees not enrolled in RGP, and creates significant financial disparities between GP supervisors and RGP trainees. There are other hospital based generalist training models but these do not necessarily provide adequate community-based care experience and training.

### **8.1.3 Scope of practice for rural generalists**

The Rural Generalists/GP Proceduralists must provide services appropriate to their level of proficiency. Rural GPs with procedural skills are an essential part of service delivery in non-metropolitan areas but should not be seen as an alternative specialist workforce.

The scope of practice must also match the facilities, availability of local support and the skills of the person. Procedures often occur in the context of a hospital based team, so the list of generalist procedures is not necessarily transferable from one location to another because of different sets of structures and working environments. It is important to ensure that RGP trainees receive sufficient experience in community primary health care, however RACGP notes there are some challenges to releasing trainees from hospital posts to undertake this, due to hospital workforce demands.

### **8.1.4 Currency of practice**

Currency of practice is an issue. Audit and peer review are considered minimum mandatory requirements for proceduralists, and especially so where these may be occasional proceduralists due to case throughput. Audits and reviews should involve competent and experienced specialists and can be facilitated through electronic means.

The DRANZCOG and DRANZCOG Advanced are time-limited qualifications requiring re-certification every 3 years. ANZCA through its JCCA requires an annual recall for CPD and on-going accreditation.

RACS is continuing to have discussions with ACCRM about scope and currency of practice for GP surgical proceduralists and these are not yet resolved.

There are some concerns on the part of Specialist Colleges about "grandfathering" of existing practitioners in the ACCRM Fellowship for employment purposes, and its consistency with College standards of practice.

## **8.2 Summary of feedback from General Practice Education and Training (GPET)**

The QRGP model is of particular interest to GPET in fulfilling its Commonwealth-funded role in facilitated delivery of general practice education and training. The development of QRGP coincides with some GPET objectives: QRGP provides a useful contribution to the targets GPET has for procedural training; QRGP is taking place at a time of increases in national training places and a growing pool of potential trainees from which to recruit; QRGP is viewed as an innovative approach to meeting the specific skills and workforce needs of rural populations.

GPET also acknowledges the efforts in other jurisdictions to address shortages in the rural general proceduralist workforce. The degree of risk associated with trainees being located in remote areas with minimal supervision was recognised a decade ago, and the more robust and formalised QRGP is viewed as a positive development.

GPET's notes the following about the QRGP program:

- The QRGP remains at this time a hospital-based model and the extent to which it can address the primary care role required of general practice has not yet been demonstrated.
- It is unclear at this time whether the QRGP model may negatively impact on other models of training. For example the cohort entering QRGP may be drawn from a subset of people particularly interested in Emergency Medicine (rather than broad GP opportunities); there may be some 'fast-tracking' of medical students if they have previously expressed an interest in rural practice; the preferential allocation of procedural training posts to QRGP trainees may negatively impacts on the access of other AGPT trainees to those posts; and there is a high dependence on the teaching hospitals. These training positions may also be excluding access by other medical workforce groups to hospitals, and together with the funding differential, may dislocate other practitioners.
- RGP applicants can pick the endpoint of training (Fellowship of ACRRM or RACGP), and most of the current cohort have selected FACRRM training. While Fellowship of both Colleges is possible, it may be difficult for trainees to have their time counted towards Fellowship of RACGP because of different accreditation requirements of the two Colleges for training posts.
- There are attractive incentives for trainees to enter QRGP. The salary component of QRGP is very generous compared to that available to General Registrars following the traditional AGPT training pathway. Trainees following the traditional AGPT pathway would receive about one third of the RGP pathway funding, and this disparity may create tension in some parts of the State and among Supervisors.
- The outcome indicators for the program have yet to be described, and GPET considers these must not overwhelm the flexibility inherent in the QRGP. Some possible indicators might include support, distribution, progress and participation rates.

### 8.3 Summary of feedback from the Australian Rural Doctors Association

The Rural Doctors Association of Australia (RDAA) and its state based affiliates are strongly supportive of the Rural Generalist Pathway and have argued for its introduction as a national initiative. The RDAA identifies that there is a critical shortage of proceduralists in rural and regional areas and believes that the Queensland model is an appropriate means of developing a workforce to address this shortage. In particular, the RDAA supports the ACRRM training model as appropriate for rural generalist practice, the quarantining of training places for rural generalist, the development of a career path for rural generalists and the provision of vocational support through the course of training.

The state affiliates of the RDAA identify that each jurisdiction has a somewhat different delivery structure for procedural and primary health care services, and the workforce structure and demands also differ. They note that Queensland has historically had a significant salaried medical workforce and has relied less upon VMOs to deliver services within regional and rural hospitals. For this reason, the state branches of the RDAA favour jurisdictional variations to the Queensland model while retaining core features. The significant variation would be with respect to the industrial relations structure in each state.

The RDAA does not believe that the different industrial relations structures should be an impediment to the national introduction of a rural generalist pathway. It notes that because of the agreements that are in place, the salaries (including rural loadings and incentives) which can be achieved by rural proceduralists in other jurisdictions are not dissimilar to those in Queensland.

## 9 Analysis and Discussion

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### 9.1 Key elements of RGP effective models or practices

This review has identified a number of critical elements for the successful implementation of a rural generalist pathway. They include:

- fostering of an interest in rural practice amongst undergraduate and pre-vocational medical students and graduates
- the adoption of an appropriate academic program (e.g. through ACRRM and RACGP) in consultation and collaboration with other relevant colleges
- the development of a coordinated training structure which addresses both employment and quality training issues
- provision of quality Advanced Skills Training and its accreditation by a relevant accrediting College
- quarantining of training places at the pre-vocational, AST and vocational levels
- an employment framework which provides for career progression, recognition of attainment and incentives for rural practice
- provision of high quality vocational support for trainees.

### 9.2 Whether the QRGP model could be implemented in other jurisdictions

The specific QRGP model was not seen as appropriate for all jurisdictions due to differences in population dispersion; number and capacity of rural hospitals; case throughput; access to specialist workforces; number and remuneration for training positions; and local mechanisms for employing doctors to provide procedural services in rural hospitals i.e. no jurisdiction other than Queensland employs salaried GPs in rural hospitals. However based on stakeholder reports, where jurisdictions have different incentive supports, remuneration and recognition arrangements to that adopted by Queensland, there may be some flow of doctors away from those jurisdictions. The specific arrangements for each jurisdiction are summarized below.

- In outer metropolitan and rural areas in New South Wales, GPs provide medical and some procedural services in hospitals through VMO arrangements.
- Western Australia relies principally on Visiting Medical Practitioners (VMPs) for rural hospital staffing.
- Northern Territory uses GPs contracted as VMO's in rural areas and uses rural/remote area nurses to provide some defined treatment protocols
- Rural facilities in South Australia operate on a VMO model providing fee for service to GP proceduralists as well as specialists. GP training is principally located in the private sector.
- Tasmania has some contracting of local GPs for inpatient care in small non -metropolitan facilities, but these are not proceduralist GPs. It has salaried MO structures for specialists, but none work in the rural facilities.
- Victoria uses VMOs extensively in rural areas. They are paid on a contractual basis for public activity and are able to obtain secure admitting rights for private activity in public hospitals. VMOs may be general practitioners or specialists.

#### 9.2.1 Barriers to implementation of the QRGP in other jurisdictions

A barrier in most jurisdictions is the model of rural generalist providing services as VMOs rather than salaried employees of the state health departments. This is unlikely to change except in the NT. This means that while the academic and training component and the vocational support elements of the QRGP model could be applied, the industrial relations strategy for each jurisdiction would be more difficult to reconcile.

The industrial conditions negotiated in Queensland may also present a cost barrier to implementation of the program in other jurisdictions. The Rural Doctors Association and ACRRM believe that the model could be adapted to the industrial relations regimes of the different jurisdictions and that the costs would not be prohibitive relative to the current incentive arrangements in place in each jurisdiction. The significant factor in this regard is that the Queensland model has systematically placed the RGP as a defined element within the



medical workforce industrial structure as a recognised medical specialty, with attendant benefits. It is this systematic approach rather than the rates of remuneration which may present a challenge in other jurisdictions.

### 9.2.2 Facilitators to implementation of the QRGP in other jurisdictions

There are a number of features of the QRGP program that may be more readily transferred to other jurisdictions. These include:

- positive selection, training and supervision policies and networks
- quarantined or preferential allocation of places to rural trainees for AST training
- providing AST early in the trainee's pathway (PGY3) with subsequent practice and employment opportunities from PGY4 and post Fellowship
- development of regional service and training networks to help build critical mass and peer support among rural GPs with AST, specialists, nursing and other members of procedural and specialist teams
- highly structured support for trainees in career planning, appointments for career development, and responsiveness to trainee's personal needs and aspirations
- support for the maintenance of skills and scope of practice
- development of appropriate IT to support practice and training networks.

### 9.3 The potential impact of the RGP on the GP workforce

QRGP trainees are employed as hospital medical officers providing general practice as an outreach of the hospital based service or with rights of private practice. There are currently 146 in training, a number almost equivalent to the total of SMORPPs, SMOs and VMOs in rural Queensland. This represents a very significant increase in the rural workforce available to undertake primary health care.

However it is unclear how many RGP trainees will become rural private sector GPs with AST. The first graduates of the QRGP are expected in 2011, thus there is no data on the impact on the GP workforce as yet. Anecdotal reports however, suggest that particularly due to the significant remuneration differential, graduates emerging from the QRGP may elect to practice in hospital settings as generalists, and not practice as traditional private sector GPs in rural settings.

In other jurisdictions, trainees in GP plus AST training programs are either private sector based GP registrars or GPs who undertake a salaried AST placement within hospital facilities (New South Wales, SA, Western Australia, NT); or salaried PGY 1-3 trainees who undertake AST modules prior to exit into a specialist training program (Western Australia).

Some stakeholders interviewed for this project reported that it has become increasingly difficult to compete with the incentives offered to QRGP trainees and graduates, and that there is some bleeding from the AST program to other specialist training programs, rather than continuing to general practice, although Queensland Health indicates that transfers to other specialist programs has not been significant and that there is reason to believe that the QRGP has attracted an additional cohort of trainees to rural primary care/procedural practice, rather than diverted trainees from more traditional private GP practice.

### 9.4 Impact on the AGPT program of national expansion of the QRGP

The QRGP model has several implications for AGPT and the network of Regional Training Providers:

- there may be competitive disadvantage to AGPT trainees not in the RGP program through:
  - remuneration differentials between hospital salaried RGP trainees and AGPT trainees employed in community general practice or Aboriginal Medical Services
  - restricting access to AST training places through quarantining of places for RGP trainees
- the larger number of AGPT trainees in Queensland are now undertaking the QRGP. The decision by Queensland Health to utilise AGPT training within the pathway makes a significant contribution to the strength and viability of the AGPT in Queensland but any decision to withdraw the pathway from AGPT and

pursue vocational training by other means, would have significant negative consequences for AGPT in Queensland

- Queensland Health's informal surveying of RGP trainees suggests that many see their ultimate future in emergency medicine or other specialism in regional centres or medical leadership in regional centres. The program may therefore contribute to building the workforce of rural GPs with the Advanced Skills Training only on a transitional basis and will require the continuing training of a new workforce.

The QRGP model also indicates there may be some development opportunities for AGPT training characterised by:

- the attraction of a significant cohort of trainees who otherwise may not have been drawn to rural practice
- giving preferential support to all rural general practice trainees to access AST places
- positive trainee selection processes which:
  - better align both the candidates' and the community's health workforce and specialism development goals
  - are contextualized in the development of statewide, regional and local service and workforce networks which support and grow service and training capacity, peer support and quality assurance.

Current Australian Government policies for the development of local health networks, increased medical and nursing training places and further development of primary care represent a positive environment for supporting GP trainees seeking careers as Rural Generalists/GP Proceduralists.

## 9.5 Any implications for specialist colleges of further development of RGP models

All specialist Colleges hold the view that Fellowship of their College is a minimum requirement for their specialism. Advanced Skills Training is not equivalent to the Fellowship requirements of any specialist College, whether undertaken at any point in the trainees pre-or post Fellowship career. Equating a procedural Fellowship with 12 months AST presents risks, in the view of the Colleges, to standards and Fellowships, and service quality,

It is important that in strategies to address workforce needs, service standards and quality are maintained and preferably enhanced.

The Colleges consulted for this review are already actively involved in rural general practice AST programs including in:

- trainee and general practitioner education provided through College Fellows
- further developing Certificates and Diplomas for recognition of training and standards by those who do not hold full Fellowship in that specialty
- service, network and workforce development, quality, and standards.

While the specialist rural workforce is limited in its capacity to meet demand, the rural generalist education models reviewed may contribute over time via:

- rural general practitioners who provide procedural skills in hospital settings (VMO or employee)
- procedural, emergency and other specialists with rural generalist training and experience.

There are also further opportunities to develop effective collaborative relationships between Colleges especially where the combination of generalism and specialism is required for service provision and where training and support is considered within the context of a regional network.

## 10 Conclusions

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### 10.1 Key elements of the QRGP model

This review has demonstrated a number of service and educational needs including that rural and remote areas in Australia require an ongoing workforce of general practitioners with advanced procedural and specialised skills to contribute to:

- meeting consumer and community expectations about access to safe and effective general practice, procedural and specialised health services
- providing services safely, efficiently and effectively based on a local community's patient profile, clinical need and available resources.

To achieve this Australia needs to train doctors who are willing to:

- practice in rural and remote areas
- complete a general practice qualification
- complete advanced skills training in a procedural or other specialty.

The stakeholders in this training are the trainees, primary allocation centres, AGPT regional training providers, health departments and services, including hospitals, public and private general practices and NGO general practice settings such as Aboriginal Medical Services, educational providers including medical schools, rural clinical schools, trainers, mentors and supervisors, professional Colleges and peak bodies representing professional groups.

The QRGP presents an innovative approach to addressing workforce and service delivery with potential for transferability at a national level. These innovations include:

- a specific and well organised pathway for training rural GPs with advanced skills
- positive selection, training and support strategies to assist trainees to efficiently and effectively negotiate and complete their training curricula and placements
- opportunities to practice as GP registrars with advanced skills at an early point in the training pathway
- positive strategies to assist postgraduate placement and employment options
- effective networking and development of stakeholder supports at training, professional development and service delivery levels.

### 10.2 Key elements of an effective RGP model

While the QRGP model was designed to match the Queensland environment there are core features that could be included in a RGP model in other jurisdictions. Some of these are outlined below.

#### 10.2.1 Engagement and agreement from key stakeholders

There are multiple stakeholders involved in developing RGP programs including state departments of health and their regional and/or area management, professional Colleges, Regional Training Providers, medical educators and RGP trainees themselves. As demonstrated in the QRGP model, each of these stakeholders needs to authorise and develop their relevant component of the program, and integrative mechanisms, such as Joint Consultative Committees and credentialing Committees (as have been put in place in Queensland), are necessary structures to support these processes.

Additionally each stakeholder needs to provide a clear commitment to the RGP and contribute to its ongoing review and development.

#### **Feature of an effective RGP model:**

*Integrative processes, mechanisms and structures such as consultative committees and credentialing committees, with membership drawn from all relevant stakeholders*

### 10.2.2 Ensuring the ongoing supply of rural GPs

Rural GP workforce development needs to consider the availability and resourcing of appropriate training positions to meet forecast service needs. This includes considering the forecast case mix and the required skills within service, team and specialist networks to support safe and effective practice within a defined scope of practice.

Resourcing considerations include both local resourcing of practicing GPs as trainers, mentors and supervisors and the resourcing of broader network supports such as coordinated allocation centres, specialist placements and supervisors.

Limited availability of, or competition for, procedural and other specialist training places has the potential to reduce access to advanced skills training for rural GP trainees. However preferential allocation or quarantining of training places for rural trainees in Queensland has been successful in significantly increasing its rural medical workforce. The impact of quarantining however should be monitored over time for impacts on the training of other members of the health workforce.

**Features of an effective RGP model include:**

*Quarantined training places for rural trainees and a process for monitoring the impact of this*

*Strategies that aim at retaining doctors in rural and remote communities including rural GPs who wish to maintain a commitment to their rural and remote hospital services*

### 10.2.3 Accommodating different employment arrangements

The new industrial agreement providing definition of a rural generalist, career structure, employment and remuneration for senior trainees and graduates at specialist-equivalent categories in Queensland Health is a major incentive to RGP trainees and postgraduates. However it creates some disparities between the employment conditions of RGP trainees and their peers in other GP training programs, and between RGP trainees and private sector GP trainers and supervisors.

In all other jurisdictions, GP registrars are offered comparatively lower classification and remuneration in hospitals for their training periods and also rely on private sector employment in rural general practices or NGOs for most of their training and release from private general practice for Advanced Skills Training can be difficult as positions may need to be backfilled.

While the Queensland industrial relations model may not be applicable in other jurisdictions, they may benefit from considering the place of rural generalists or rural GPs with advanced skills in training within their respective professional and industrial structures.

**Features of an effective RGP model include:**

*A defined role for the rural generalist/ rural GP with advanced skills within professional and employment structures*

*Attention is paid to addressing any potential disparity in recognition and reward between general practitioners and rural generalist/ rural GP with advanced skills*

### 10.2.4 Ensuring quality of training

Quality of training is properly determined by the respective Learned Colleges. In the case of the QRGP the relevant colleges are ACRRM and RACGP. While there is some disagreement between these Colleges with respect to the required content of their respective curricula, both are recognised for the accreditation of general practice in Australia.

Additionally, a system for supporting and training workplace supervisors will further assure the quality of training.

**Features of an effective RGP model include:**

*The arrangements for training and credentialing of trainees are agreed by all relevant bodies to ensure there are no misconceptions about skill gaps between alternative qualifications.*

### 10.2.5 Providing adequate resourcing

Resourcing considerations to meet service and training needs will include funding of incentives for doctors to train in rural general practice and advanced procedural and specialised skills including:

- the training costs (including opportunity costs) to a range of stakeholder participants, for example trainees, mentors and supervisors and training facilities
- the ongoing practice costs to graduates for maintenance of their professional and service provision for example practice viability and currency of practice
- accommodation and travel costs associated with placements and accessing training
- the development and maintenance of training and service supports to doctors in rural practices including networks of practice teams and specialist support and ongoing training and professional development.

**Features of an effective RGP model include:**

*Appropriate resourcing to cover all aspects of training delivery, and ongoing support for graduate practitioners within service delivery networks*

### 10.2.6 Addressing process issues

The QRG model has closely aligned selection, training and placement processes with the overall RGP model and pathway. In other jurisdictions, these processes are less closely aligned and this is reported to act as a disincentive to prospective trainees, especially where they are left to organise their own training placements or where they are required to participate in allocation processes that are not supportive of the rural GP training pathway.

**Features of an effective RGP model include:**

*An integrated system for the selection, training and placement of trainees which are supportive of them*

*Provision of coordinated approach to placement of RGP trainees*

### 10.2.7 Providing an appropriate orientation to primary health care practice

In recent times there has been a tendency towards increasing sub-specialisation which has coincided with a marked decline in the rural medical workforce. The success of the QRG in attracting and retaining a significant cohort of medical graduates with an indicated preference for rural generalist practice reflects a significant reversal in recent trends in medical workforce development. It also suggests that a generalist focus, combined with advanced skills development and recognition, articulated career pathways and strong vocational support, can provide an attractive alternative for medical graduates. The training of such a workforce may provide a strong basis for further development of rural primary health care.

There is much discussion associated with the RGP about the model of primary health care for which a workforce should be trained. Some of this discussion is focused on a disjunction between proceduralist or hospital based primary care and traditional private sector general practice. The structure of primary health care in Australia is however in the process of considerable change.

Alternative models of health financing, models of interprofessional practice, jurisdictional responsibilities and professional demarcations are all under review and demographic and lifestyle expectations are impacting upon workforce structure and expectations. In this context, traditional modes of general practice are likely to be considerably changed. The challenge is to prepare a workforce for future requirements not for those of the past.

While it is not possible to accurately delineate future primary health care practice, it might be anticipated that a generalist workforce with a capacity to work flexibly in a range of environments, both procedural and ambulatory, would be well placed to respond to new models of practice.

**Features of an effective RGP model include:**

*Provision of a range of training environments to enable the development of a responsive and flexible primary care workforce with the range of skills to meet the needs of the community, including access to training in community based general practice environments*

*Provision of sufficient suitable placements to enable the develop of the required skills including procedural posts*

## Appendix A Stakeholders consulted

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### Stakeholder name and organisation

#### Queensland Health

Dr Denis Lennox, Executive Director, Rural and Remote Medical Services

#### GPET

Prof Willcock, a number of the GPET Board Directors, Erich Jansen and GPET Senior Executive

#### New South Wales Health Department

Robyn Burley, Director of Workforce Development and Innovation

Maggie Crowley, A/Mgr State-wide Education Policy

Praveen Sharma, Senior Policy Officer

#### ACT Health Department

Ms Judi Childs, Executive Director, Human Resource Management Branch

#### South Australia Health Department

Etienne Scheepers, Executive Director, Workforce Division

Professor Paddy Phillips, Chief Medical Officer

Brendan Peake, Manager, Education and Training

Dr Jeff Thompson, Director South Australia Institute of Medical Education and Training (IMET)

#### Tasmania Department of Health and Human Services

Dr George Cerchez, Director, Medical Workforce and Integration - Primary and Rural

#### Northern Territory Department of Health and Families

Dr Alan Ruben, Principal Medical Advisor

Judy Mills, Senior Workforce Consultant, People and Organisational Learning

#### Victoria Health Department

Kim Sykes, Director Portfolio Services & Strategic Projects

#### Western Australia Health Department

Dr Felicity Jefferies, Executive Director, Medical Services. Western Australia Country Health

Sue Brooks, A/Director, Workforce. Department of Health, Western Australia

**Rural Doctors Association of Australia**

Steve Sant, National President

Dr Sheilagh Cronin, RDAA President Queensland

Dr Rod Whitehead, immediate past President, RDAA Western Australia

Dr Michael Moynahan, RDAA President, Victoria

Dr Ian Kamerman, RDAA President New South Wales

Dr Graeme Morris, RDAA President, SA

**Australasian College for Emergency Medicine**

Dr Sally McCarthy, President

**Australian and New Zealand College of Anaesthetists**

Dr Michael Steyn, Deputy Chair, Queensland Regional Committee

Dr Mark Gibbs, Regional Education Officer, Chair of Anaesthetic Rotation Queensland, NT, New South Wales

**The Royal Australian & New Zealand College of Obstetricians and Gynaecologists**

Dr Peter White, Chief Executive Officer

Dr Rupert Sherwood, President-Elect and RANZCOG Chair of Education and Training

**Royal Australasian College of Surgeons**

Dr David Hills, Chief Executive Officer

Dr John Quinn, Executive Director, Surgical Affairs

**The Royal Australian College of General Practitioners**

Dr Chris Mitchell, President

Dr Kathy Kirkpatrick, Chair National Rural Faculty

Associate Professor Jane Smith, Chair, Queensland Faculty

Dr Brendan Grabau, Director of Education

Dr Peter Marshall, National Manager, Rural Faculty

**The Australian College of Rural and Remote Medicine**

Dr Dennis Pashen, Chief Executive Officer

Ms Marita Cowie

**Central and Southern Queensland Training Consortium Ltd**

Mr Peter Harrison

Chief Executive Officer

**Queensland Rural Medical Education**

Adjunct Professor Scott Kitchener

Medical Director / Chief Executive Officer

**Tropical Medical Training**

Mr Ian Hook, Chief Executive Officer

**Far North Queensland Rural Division of General Practice**

Dr Rod Nan Tie

Medical Educator, Dr Patrick O'Neill

Rural/RACGP Advisor, Shaun Grimes

**James Cook University**

Prof Richard Murray Dean of Medicine

Dr Tarun San Gupta , Director of Medical Education

Dr Glen Barker, QRGP Trainee

Dr Suzette Price, QRGP trainee

**Health Workforce Queensland.**

Dr Chris Mitchell, Director



# Appendix B Review questions per stakeholder group

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## Queensland Health

### Context

1. What is the rationale behind the program
2. What factors influenced establishment of the program e.g. demand from trainees, health needs, geographic, workforce etc
3. What are the objectives of the program
4. What rural GP recruitment goals have been achieved through the program?
5. Are you aware of similar programs in other jurisdictions and/or overseas
6. What further developments are planned for the program e.g. expansion of training places, locations, structures, curricula
7. How sustainable is the model for getting procedural GPs in rural areas

### Relationships

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

### Stakeholders

1. What is the value of this rural generalist model
2. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
3. What is the scope of practice of completed trainees
4. Is this scope of practice recognised in other jurisdictions

### Resourcing

1. What resourcing is required for the program i.e. HR and clinical support, mentoring, facilities for training, allocation of funds for salaries, training etc
2. How are trainees employed? Paid?
3. How are training organisations paid?
4. What financial commitment is required of trainees (fees, bonds, training, assessment and examination costs, professional membership etc)
5. What other commitments are required of trainees (bonds and/or return of service obligations)
6. What insurances are required of trainees and other participants
7. Are other incentives provided to trainees e.g. work/life incentives, leave, locum relief, family support, relocation costs etc

### Trainee profile

1. How many trainees are in the program by pathway year?
2. What are the trainee demographics: age, gender?
3. What are the sources of trainees e.g. Australian medical schools, International Medical Graduates etc?
4. What are the entry points for Australian graduates in the RGP/rural training pathway?
5. What are the entry points for IMGs in this program? Do they undertake all the training or is there recognition of prior learning?
6. Who are the other program participants: e.g. GP and specialist supervisors, mentors, educators, training practice providers?
7. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

## **Training program details**

1. What is the Annual target for trainees and are they generally met?
2. How many trainees take up the program? Complete the program?
3. How many trainees leave the program prior to completion and the reasons for this?
4. What are the provisions for interrupted training e.g. maternity leave?
5. How is the program promoted to trainees and training providers
6. What are the successful elements of this promotion strategy
7. How are trainees selected
8. How are training providers selected/allocated
9. What are the training locations
10. How are training places allocated

## **Details of the training**

1. On what standards is the training based?
2. What is the training content?
3. What is the training duration?
4. How do the training processes address program content?
5. How is support and supervision provided e.g. teaching, supervision and mentoring?
6. What training logs and documentation are required?
7. How are trainees assessed and credentialed?

## **Outcomes for trainees**

1. How many graduates are retained in rural hospital, GP, RFDS, AMS after training? (after 2 years, after 5 years)
2. To what extent do graduates continue to practice as GPs after the program?
3. To what extent do graduates continue to practice the advanced skills after the program?
4. Where else do graduates go after completion; e.g. career paths and progression, locations?
5. To what extent do trainees achieve RACGP and or ACCRM Fellowship with advanced procedural skills upon completion?
6. What is the recognition of the rural generalist as a specialty across jurisdictions
7. How is currency of practice maintained after qualification?

## **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? e.g. maintaining local Obstetrics and Gynaecology
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

## **Other jurisdictions**

### **Context**

1. What is the rationale behind the program
2. What factors influenced establishment of the program e.g. demand from trainees, health needs, geographic, workforce etc
3. What are the objectives of the program
4. What rural GP recruitment goals have been achieved through the program?
5. Are you aware of similar programs in other jurisdictions and/or overseas
6. What further developments are planned for the program e.g. expansion of training places, locations, structures, curricula

7. How sustainable is the model for getting procedural GPs in rural areas

### **Relationships**

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

### **Stakeholders**

3. What is the value of this rural generalist model
4. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
5. What is the scope of practice of completed trainees
6. Is this scope of practice recognised in other jurisdictions

### **Resourcing**

1. What resourcing is required for the program i.e. HR and clinical support, mentoring, facilities for training, allocation of funds for salaries, training etc
2. How are trainees employed? Paid?
3. How are training organisations paid?
4. What financial commitment is required of trainees (fees, bonds, training, assessment and examination costs, professional membership etc)
5. What other commitments are required of trainees (bonds and/or return of service obligations)
6. What insurances are required of trainees and other participants
7. Are other incentives provided to trainees e.g. work/life incentives, leave, locum relief, family support, relocation costs etc

### **Trainee profile**

1. How many trainees are in the program by pathway year?
2. What are the trainee demographics: age, gender?
3. What are the sources of trainees e.g. Australian medical schools, International Medical Graduates etc?
4. What are the entry points for Australian graduates in the RGP/rural training pathway?
5. What are the entry points for IMGs in this program? Do they undertake all the training or is there recognition of prior learning?
6. Who are the other program participants: e.g. GP and specialist supervisors, mentors, educators, training practice providers?
7. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

### **Training program details**

1. What is the Annual target for trainees and are they generally met?
2. How many trainees take up the program? Complete the program?
3. How many trainees leave the program prior to completion and the reasons for this?
4. What are the provisions for interrupted training e.g. maternity leave?
5. How is the program promoted to trainees and training providers
6. What are the successful elements of this promotion strategy
7. How are trainees selected
8. How are training providers selected/allocated
9. What are the training locations
10. How are training places allocated

### **Details of the training**

1. On what standards is the training based?
2. What is the training content?

3. What is the training duration?
4. How do the training processes address program content?
5. How is support and supervision provided e.g. teaching, supervision and mentoring?
6. What training logs and documentation are required?
7. How are trainees assessed and credentialed?

### **Outcomes for trainees**

1. How many graduates are retained in rural hospital, GP, RFDS, AMS after training? (after 2 years, after 5 years)
2. To what extent do graduates continue to practice as GPs after the program?
3. To what extent do graduates continue to practice the advanced skills after the program?
4. Where else do graduates go after completion; e.g. career paths and progression, locations?
5. To what extent do trainees achieve RACGP and or ACCRM Fellowship with advanced procedural skills upon completion?
6. What is the recognition of the rural generalist as a specialty across jurisdictions
7. How is currency of practice maintained after qualification?

### **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? e.g. maintaining local O&G
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

## **GPET**

### **Context**

1. Are you aware of similar programs in other jurisdictions and/or overseas
2. How sustainable is the model for getting procedural GPs in rural areas

### **Relationships**

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

### **Stakeholders**

1. What is the value of this rural generalist model
2. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
3. What is the scope of practice of completed trainees
4. Is this scope of practice recognised in other jurisdictions

### **Trainee profile**

1. How many trainees are in the program by pathway year?
2. What are the trainee demographics: age, gender?
3. What are the sources of trainees e.g. Australian medical schools, International Medical Graduates etc?
4. What are the entry points for Australian graduates in the RGP/rural training pathway?

## **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? e.g. maintaining local O&G
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

## **ACRRM**

### **Context**

1. What factors influenced establishment of the program e.g. demand from trainees, health needs, geographic, workforce etc
2. What are the objectives of the program
3. What rural GP recruitment goals have been achieved through the program?
4. Are you aware of similar programs in other jurisdictions and/or overseas
5. How sustainable is the model for getting procedural GPs in rural areas

### **Relationships**

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

### **Stakeholders**

1. What is the value of this rural generalist model
2. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
3. What is the scope of practice of completed trainees
4. Is this scope of practice recognised in other jurisdictions

### **Resourcing**

1. What resourcing is required for the program i.e. HR and clinical support, mentoring, facilities for training, allocation of funds for salaries, training etc
2. What financial commitment is required of trainees (fees, bonds, training, assessment and examination costs, professional membership etc)

### **Trainee profile**

1. What are the entry points for Australian graduates in the RGP/rural training pathway?
2. What are the entry points for IMGs in this program? Do they undertake all the training or is there recognition of prior learning?
3. Who are the other program participants: e.g. GP and specialist supervisors, mentors, educators, training practice providers?
4. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

### **Outcomes for trainees**

1. To what extent do trainees achieve RACGP and or ACCRM Fellowship with advanced procedural skills upon completion?
2. What is the recognition of the rural generalist as a specialty across jurisdictions
3. How is currency of practice maintained after qualification?

## **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? e.g. maintaining local Obstetricians and Gynaecologists
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

## **RACGP**

### **Context**

1. What is the rationale behind the program
2. What factors influenced establishment of the program e.g. demand from trainees, health needs, geographic, workforce etc
3. What are the objectives of the program
4. What rural GP recruitment goals have been achieved through the program?
5. Are you aware of similar programs in other jurisdictions and/or overseas
6. What further developments are planned for the program e.g. expansion of training places, locations, structures, curricula
7. How sustainable is the model for getting procedural GPs in rural areas

### **Relationships**

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

### **Stakeholders**

1. What is the value of this rural generalist model
2. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
3. What is the scope of practice of completed trainees
4. Is this scope of practice recognised in other jurisdictions

### **Resourcing**

1. What resourcing is required for the program i.e. HR and clinical support, mentoring, facilities for training, allocation of funds for salaries, training etc
2. How are trainees employed? Paid?
3. What financial commitment is required of trainees (fees, bonds, training, assessment and examination costs, professional membership etc)

### **Trainee profile**

1. What are the entry points for IMGs in this program? Do they undertake all the training or is there recognition of prior learning?
2. Who are the other program participants: e.g. GP and specialist supervisors, mentors, educators, training practice providers?
3. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

### **Outcomes for trainees**

1. To what extent do trainees achieve RACGP and or ACCRM Fellowship with advanced procedural skills upon completion?

2. What is the recognition of the rural generalist as a specialty across jurisdictions
3. How is currency of practice maintained after qualification?

### **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? e.g. maintaining local Obstetricians and Gynaecologists
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

### **Other Colleges**

#### **Context**

1. What factors influenced establishment of the program e.g. demand from trainees, health needs, geographic, workforce etc
2. What are the objectives of the program
3. What rural GP recruitment goals have been achieved through the program?
4. Are you aware of similar programs in other jurisdictions and/or overseas
5. How sustainable is the model for getting procedural GPs in rural areas

#### **Relationships**

1. What are the links between this program and strategies to address other workforce groups e.g. physician assistants, nurses, specialists
2. What is the relationship between the program and the Rural Clinical Schools

#### **Stakeholders**

1. What is the value of this rural generalist model
2. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
3. What is the scope of practice of completed trainees
4. Is this scope of practice recognised in other jurisdictions

#### **Outcomes for trainees**

1. What is the recognition of the rural generalist as a specialty across jurisdictions
2. How is currency of practice maintained after qualification?

#### **Outcomes for services**

1. How has having rural generalists impacted on the provision of health services? eg maintaining local Obstetricians and Gynaecologists
2. Has having rural generalist impacted on other health workforce groups? (e.g. physician assistants, nurses, specialists)
3. What rural GP recruitment goals have been achieved through the program?
4. What, if any have been the impacts of the program on other/adjoining regions (e.g. workforce impacts) and/or other specialties within the region (e.g. take-up)

### **Training Organisations**

#### **Context**

1. Are you aware of similar programs in other jurisdictions and/or overseas

## **Relationships**

2. What is the relationship between the program and the Rural Clinical Schools

## **Stakeholders**

3. What is the value of this rural generalist model
4. What are your views about the training outcomes from the program i.e. concordance with standards, training content and delivery, practice levels, equivalence with specialist training
5. What is the scope of practice of completed trainees
6. Is this scope of practice recognised in other jurisdictions

## **Resourcing**

1. What resourcing is required for the program i.e. HR and clinical support, mentoring, facilities for training, allocation of funds for salaries, training etc
2. How are training organisations paid?

## **Trainee profile**

1. How many trainees are in the program by pathway year?
2. What are the trainee demographics: age, gender?
3. What are the sources of trainees e.g. Australian medical schools, International Medical Graduates etc?
4. What are the entry points for Australian graduates in the RGP/rural training pathway?
5. What are the entry points for IMGs in this program? Do they undertake all the training or is there recognition of prior learning?
6. Who are the other program participants: e.g. GP and specialist supervisors, mentors, educators, training practice providers?
7. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

## **Training program details**

1. How is the program promoted to trainees and training providers
2. What are the successful elements of this promotion strategy
3. How are training places allocated
4. Details of the training
5. On what standards is the training based?
6. What is the training content?
7. What is the training duration?
8. How do the training processes address program content?
9. How is support and supervision provided e.g. teaching, supervision and mentoring?
10. What training logs and documentation are required?
11. How are trainees assessed and credentialed?

## **Outcomes for trainees**

1. How many graduates are retained in rural hospital, GP, RFDS, AMS after training? (after 2 years, after 5 years)
2. To what extent do graduates continue to practice as GPs after the program?
3. To what extent do graduates continue to practice the advanced skills after the program?
4. Where else do graduates go after completion; e.g. career paths and progression, locations?
5. How is currency of practice maintained after qualification?



## Trainees

### **Trainee profile**

1. What are key motivators for trainees (salary/benefits, qualifications, preference for rural practice, work/life balance)?

### **Training program details**

2. How is the program promoted to trainees and training providers
3. What are the successful elements of this promotion strategy

### **Outcomes for trainees**

1. How many graduates are retained in rural hospital, GP, RFDS, AMS after training? (after 2 years, after 5 years)
2. To what extent do graduates continue to practice as GPs after the program?
3. To what extent do graduates continue to practice the advanced skills after the program?
4. Where else do graduates go after completion; e.g. career paths and progression, locations?
5. To what extent do trainees achieve RACGP and or ACCRM Fellowship with advanced procedural skills upon completion?
6. What is the recognition of the rural generalist as a specialty across jurisdictions
7. How is currency of practice maintained after qualification?

## Appendix C Literature Review

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A broad scan was undertaken of literature relevant to rural generalism. This was not a comprehensive and systematic literature review, but an attempt to identify emergent themes and issues relevant to the GRGP review and to inform development of the analytic framework for this review.

The literature scan was structured to include published professional and consumer literature published after 2000, reflecting the contemporary focus on rural generalist practice. The scan included other non-peer reviewed and unpublished document sources such as reviews and reports on health policy and program initiatives and reports and position statements from Australian and overseas Specialist Medical Colleges regarding rural generalism and rural general practice.

### 10.3 The changing nature of rural general practice

The literature indicated there are a number of significant factors influencing the decisions of general practitioners to not practice in rural locations. These include changes in the medical workforce, lifestyle and personal circumstances of the practitioners, lack of opportunity and access to educational and collegial support system or organisational support and the nature of the expected practice, based on remoteness. These are discussed below.

#### 10.3.1 Workforce profile

The medical workforce is changing as are the lifestyle aspirations of general practitioners. There is a growing body of literature that documents the loss of generalist specialists and the decline in the number of procedurally skilled generalists both here and abroad that in part the decline is a reflection of earlier policies, developments in technology and emergent workforce expectations. This in turn has impacted upon the rural medical workforce and the structure of primary care and procedural services in rural areas. New Zealand studies<sup>23</sup> identified for instance a trend for younger doctors who:

- want to work part-time
- work in group practices
- do not own their practice.

All of these have significant implications for the rural workforce shortage especially as older rural GPs retire.

A study undertaken in Ontario, Canada<sup>24</sup> found that lifestyle considerations were an important influence for 93.1% of medical students. Another Canadian study of North-Western Ontario physicians (predominantly in an urban location) found that family/community, time, professional support and efficacy, and sense of belonging and appreciation affected future practice intentions of physicians who practice in rural and underserved areas<sup>25</sup>. It found that over two-thirds of North-Western Ontario physicians intended to remain in practice in 5 years. These Physicians were significantly more likely to intend to stay in practice if they were younger, practised in the major city (regional centre) and scored higher on the family/community scale.

#### 10.3.2 Inhibitors to choosing rural general practice

In addition to these personal factors however, breadth and scope of practice appear to be significant factors affecting a choice for a rural family medicine/general practice career. An investigation of family medicine

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<sup>23</sup> Janes, R., D. Cormack and A. Dowell. 2005. "New Zealand rural general practitioners 1999 survey part 4: analysis of specific sub-groups." *N Z Med J* 118(1208):U1256. Jones, M., J. Humphreys and D. Prideaux. 2009. "Predicting medical students' intentions to take up rural practice after graduation." *Med Educ* 43(10):1001-1009

<sup>24</sup> Jutzi, L., K. Vogt, E. Drever and J. Nisker. 2009. "Recruiting medical students to rural practice: perspectives of medical students and rural recruiters." *Can Fam Physician* 55(1):72-73, 73 e71-74.

<sup>25</sup> Kelley, M. L., K. Kuluski, K. Brownlee and S. Snow. 2008. "Physician satisfaction and practice intentions in Northwestern Ontario." *Can J Rural Med* 13(3):129-135.

graduates' career choices by the University of Calgary in Alberta<sup>26</sup>, found that most residents initially planned to do urban locums in order to gain experience. In the long term, they planned to open practices in urban areas for lifestyle and family reasons and many residents from the rural training stream had no long-term plans to establish rural practices.

Reasons cited for not practising in rural areas were related to workload, lifestyle issues, family obligations, and perceived lack of medical support in the community. Most residents said they felt prepared for practice, but indicated that an optional third year of paid training, with an emphasis on emergency medicine, obstetrics, and paediatrics, would be desirable. Only 4 female graduates and 1 male graduate intended to practise obstetrics, and attributed this decision to their perceptions of inadequacy in obstetrics training during their residency. In this study, financial factors were cited as a secondary reason for many choices, although at least one Australian report (Stratigos and Nichols, 2002)<sup>27</sup> reported that inadequate or inequitable remuneration to compensate for personal and family disruption, together with the costs of maintaining an extended skill set, were factors in withdrawing from procedural rural practice.

Other impediments to Australian rural practice that were reported included limited rural pathway options, limited rural training positions, and inflexibility in training positions to accommodate personal needs (Stagg, Greenhill & Worley, 2009)<sup>28</sup>.

Ely et al (2008)<sup>29</sup> indicated that the decision to enter rural practice depends in part on decisions taken while not in a rural setting; however the decision to remain in rural practice occurs in the context and experience of that practice.

### 10.3.3 The movement towards GP with procedural skills

The review of the literature confirmed that the requirement for general practitioners with advanced procedural skills is an international phenomenon. The size and location of many small rural communities, impedes their ability to sustain specialist services such as obstetrics, surgery, emergency medicine and anaesthetics, making communities increasingly reliant on local general practitioners to deliver advanced procedural skills as part of the care they provide. The literature indicated that this reliance on GP's increases with increasing remoteness and is coupled with issues related to providing quality of care in environments where there is a lack of case throughput and procedural skills.

A study by Angle, Kurtz Landy *et al*<sup>30</sup> (2009), explored barriers physicians encountered in providing obstetric anaesthesia care in Ontario community hospitals experiencing low volumes (fewer than 2,000) deliveries per annum. The barriers included lack of time, need for continuing medical education, need for hospital infrastructure support to develop and implement best practice protocols, and need for resources and anaesthesia mentorship supports from the system. Difficulties were greatest for GP anaesthetists in rural communities who described lack of locums, need for relevant CME, and worsening physician shortages threatening provision of services in some rural hospitals. Family practitioner anaesthetist multi-taskers (generalists) were seen as the best solution to the provider shortage in rural communities. Participants described the need for increased numbers of GP anaesthetists and the development of formal funded networks for knowledge transfer between academic and community hospitals as a mechanism to provide supports.

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<sup>26</sup> Lu, D. J., J. Hakes, M. Bai, H. Tolhurst and J. A. Dickinson. 2008. "Rural intentions: factors affecting the career choices of family medicine graduates." *Can Fam Physician* 54(7):1016-1017 e1015.

<sup>27</sup> Stratigos S & Nichols A. 2002. Procedural rural medicine: strategies towards solutions. A paper prepared for the AHMAC National Rural Health Policy Subcommittee, October 2002. [www.rdaa.com.au/uploaded\\_documents/ACF3835.pdf](http://www.rdaa.com.au/uploaded_documents/ACF3835.pdf) (Accessed 07/05/10).

<sup>28</sup> Stagg P, Greenhill J & Worley PS. 2009. A new model to understand the career choice and practice location decisions of medical graduates. *Rural and Remote Health*, 9(4):1245.

<sup>29</sup> Eley D, Young L, Shrapnel M, Wilkinson D, Baker P & Hegney D. (2008) Medical Students and rural general practitioners: congruent views on the reality of recruitment into rural medicine.

<sup>30</sup> Angle, P., C. Kurtz Landy, Y. Murthy and P. Cino. 2009. "Key issues and barriers to obstetrical anesthesia care in Ontario community hospitals with fewer than 2,000 deliveries annually." *Can J Anaesth* 56(9):667-677.

Rivet, Ryan and Stewart<sup>31</sup> in a further Canadian study, examined whether there was a relationship in family medicine between higher overall job satisfaction and doing a wider range of procedures. In a sample of almost 20,000 physicians, the range of procedures done by family physicians was significantly associated with overall job satisfaction. The larger the range of procedures, the more satisfied the physician. The percentage of those very satisfied ranged from 28.1% for family physicians who did only a few procedures to 33.5% for those who did 10 or more procedures. Greater satisfaction was reported by very young and very old male physicians, those in solo practice, rural physicians, teachers, those who had fewer constraints to medical care services, and those who thought their balance of personal and professional commitments was about right.

A Japanese study<sup>32</sup> which examined the relationship between the personal and educational backgrounds of rural doctors and their intention to continue a rural career found that postgraduate training in general internal medicine, general surgery, anaesthesiology, paediatrics and gastroenterology were positively related with the intention to continue a rural career.

#### 10.4 Rural Generalism

The literature confirmed that rural generalism is not a recent phenomenon. Historically, in the U.K., rural health care delivery has focused on medically qualified general practitioners or family physicians providing primary care services, together with isolated small hospitals providing limited specialist services such as surgery, obstetrics, and internal medicine<sup>33</sup>.

Hays, Veitch and Evans<sup>34</sup> noted that a substantial proportion of health services for rural Australians continue to be provided in rural health facilities by rurally based generalist health professionals. These services include procedural care within smaller rural hospitals, where teams of health professionals: medical practitioners; nurses; and other support staff, work in teams to deliver a range of procedural services, both elective and urgent, that reduce the need for rural people to travel to major centres. They noted that debate over the training of rural medical practitioners focused on whether or not they need to provide procedural services, because current health service management policy appears to support the rationalisation and centralisation of service delivery in larger centres to contain costs and ensure high quality.

Hays, Veitch and Evans argued that consideration of the quality of procedural rural medical care should include the needs and expectations of those living and working in a smaller, more familiar environment. This has implications for health planners, and suggested that there is a continuing need for rural health professionals to be trained to provide procedural medical services in rural hospitals, and for rural hospitals to be maintained at a standard necessary to support quality service provision.

A similar practice was identified in Canada.<sup>35</sup> Despite a sharp decline in the number of rural Canadian communities that offered local maternity care, there remained significant numbers of small rural maternity services that provided elective maternity care without on-site access to caesarean section. In communities with an elective maternity service without local access to surgical capability, generalist practitioners were required to respond to obstetric emergencies and arrange urgent transfer if a caesarean section was indicated.

Symmons and Curry<sup>36</sup> described the role of the hospital generalist in rural Papua New Guinea (PNG) and the contribution of emergency medicine training to that practice. Generalist practice in Tinsley District Hospital in

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<sup>31</sup> Rivet, C., B. Ryan and M. Stewart. 2007. "Hands on: is there an association between doing procedures and job satisfaction?" *Can Fam Physician* 53(1):93, 93:e 91-95, 92.

<sup>32</sup> Matsumoto, M., M. Okayama, K. Inoue and E. Kajii. 2005. "Factors associated with rural doctors' intention to continue a rural career: a survey of 3072 doctors in Japan." *Aust J Rural Health* 13(4):219-225  
<sup>33</sup> Godden, D. J. 2005. "Rural health care in the U.K.: a rapidly changing scene." *J Agric Saf Health* 11(2):205-210.

<sup>34</sup> Hays, R. B., C. Veitch and R. J. Evans. 2005. "The determinants of quality in procedural rural medical care." *Rural Remote Health* 5(4):473.

<sup>35</sup> Kornelsen, J. A. and S. W. Grzybowski. 2008. "Obstetric services in small rural communities: what are the risks to care providers?" *Rural Remote Health* 8(2):943

<sup>36</sup> Symmons, D. and C. Curry. 2007. "Rural hospital generalist and emergency medicine training in Papua New Guinea." *Emerg Med Australas* 19(2):151-154

Western Highlands Province has an emphasis on emergency surgery and anaesthesia. The hospital serves a population of 40,000 people, with 4000 admissions and 300-400 operations performed annually. Over 16 months, doctors performed 243 emergency surgical procedures including orthopaedics, general surgery, obstetrics and gynaecology. The generalist in rural hospitals is required to perform a wide variety of medical tasks in isolated settings yet there is no active postgraduate training program. A Master of Medicine, Emergency Medicine program includes rotations through the major disciplines of surgery, anaesthesia, internal medicine, paediatrics, obstetrics and gynaecology.

## 10.5 Australian approaches to rural generalism

Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics, emergency medicine and anaesthesia. There is a community expectation that rural doctors will acquire and maintain sufficient procedural skills to provide a high level of care. The literature indicated that rural doctors in Australia and elsewhere provide more procedural care than do their urban counterparts (who for a number of reasons have tended to focus on providing office-based practice). Nevertheless the number of procedural services has declined over time and several reports pointed to a range of factors underpinning this decline. The literature also contained a range of inquiries, reviews and research, pointing concerning the need for a rural generalist workforce in Australia and pointing to strategies intended to alleviate the growing shortages. Samples of these are summarized below.

- *Improving Maternity Services in Australia: The Report of the Maternity Services Review*<sup>37</sup> identified that people living in rural and remote areas face a number of health inequities, many of which result from, or are exacerbated by, problems in accessing health care services. For rural and remote communities, accessing appropriate maternity services raises particular issues, aggravated by the need for ongoing care throughout pregnancy and, for higher risk pregnancies, the requirement for a significant period of hospitalisation prior to and sometimes after the birth.

The *Maternity Services Review* noted that twenty per cent of rural and remote GPs are proceduralists, providing non-referred services normally in a hospital theatre, maternity setting or other appropriately equipped facilities. GP proceduralists often provide services that in urban areas are typically provided by specialists, most commonly in the fields of surgery, anaesthetics and obstetrics. However the Rural Health Workforce Australia report for 2007 showed that 896 rural GPs undertook procedural work and that between 2002 and 2007, the number of procedural GPs providing obstetric services fell from 706 to 599.

The *Maternity Services Review* recommended that given the role of the states and territories in the provision of maternity services in rural areas, the availability of rural maternity services is a priority area for a national Maternity Services Plan, requiring the engagement of all states and territories.

- The *Australian Primary Health Care Research Institute* undertook a systematic review of the Australian and international literature concerning rural generalism<sup>38</sup>. *Inter alia*, this review concluded that:
  - articulated "generalist" pathways in training within hospital and community sectors provide a solution to the skills shortages in rural and remote communities
  - significant workforce enhancers are already in place and can be further enhanced by additional incentives and infrastructure within rural and remote communities
  - Commonwealth and State divides in community and facility-based training need to be synchronised to reduce barriers to more expedient training of generalists
  - the opportunity exists for the rural and remote medical education sector to collaborate to influence the redesign of education and training arrangements to create efficiencies, facilitate cross accreditation arrangements, (including streamlining) in the promotion of generalism and new career pathways in rural medicine from medical school to continuing professional development

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<sup>37</sup> Commonwealth of Australia (2009). *Improving Maternity Services in Australia: The Report of the Maternity Services Review*. Canberra.

<sup>38</sup> Australian Primary Health Care Research Institute (2007). *The Expanding Role of the Rural Generalist in Australia - A Systematic Review*. Canberra, Australian Primary Health Care Research Institute,

- it is beneficial to develop training coalitions of all relevant organisations such as Universities, Rural Clinical Schools, PGMEC and National Advisory Health Workforce Improvement Agency will assist in:
  - contributing to the reform of education and training arrangements to facilitate contestability
  - ensuring the recognition of rural and remote medicine by the new national accreditation agency
  - supporting education and training initiatives required for safe delegated practice arrangements
  - contributing to multidisciplinary training initiatives
- better support should be provided for Universities committed to the training of generalists
- funding should be allocated for development and trialing of accelerated pathways to vocational recognition for rural medicine generalists (curricula, mapping, tracking and recording mechanisms, RPL processes, joint rural clinical placement accreditation arrangements)
- the Queensland rural generalist initiative should be extended to other states to facilitate shared accreditation and educational arrangements at prevocational levels. (Note the Queensland Rural Generalist Pathway is described in detail elsewhere in this Report).
- In 2006, *WA Country Health Service (WACHS)* undertook a consultation with rural medical practitioners. The report of the consultations<sup>39</sup> made recommendations on a range of issues including improving relationships, workplace safety and suggested actions to address emerging workforce shortages. A number of the recommendations relating to workforce training, attraction and retention in WA, also relate to the Queensland Rural Generalist Pathway. Included in the report were recommendations relating to:
  - *recruitment and retention* - this requires attention to modern information and communication technology to support patient care, communication and connectivity between hospitals, doctors' surgeries and other clinical services, and the collegial development of succession plans and support for rural proceduralists in recognition of the low entry rates into the generalist proceduralists field of medicine so crucially important to the country health care system.
  - *education*- this includes recognition and adoption of relevant curriculum and training centres for rural proceduralists; capacities to enable staff rotations between metropolitan and rural centres; the expansion of 'learning hubs', allowing more PGY1 and 2's to train and learn in regional centres; and expansion of existing Rural Clinical School programs as an effective strategy for attracting new graduates to rural practice. It is also necessary to examine the potential for UK "general registered" doctors to be included into the Australian GP training program in preparation for hospital based positions in rural areas.
  - *remuneration* – including awarding a premium under Medicare Australia to country doctors possessing the Fellowship of the Australian College for Rural and Remote Medicine (FACRRM) in recognition of them being rural medical specialists.
  - *conducting a pilot on* the integration of ambulatory and primary care services currently provided by a range of service providers and examine alternative models for the provision of these services. Models to be developed in collaboration with rural doctors, health advisory groups and local government should consider provision of multidisciplinary, ambulatory care and primary care services from a general practice model under a pilot arrangement.
  - *expansion of the role of nurse practitioners* - within the country health system and including in accident and emergency departments.
- *Rural Health West* (formerly WA Council for Rural and Remote Medicine) completed a consultancy in 2007 to determine the feasibility of establishing a Rural Generalist Pathway in Western Australia<sup>40</sup>. The consultancy was funded by the Western Australian Department of Health. An audit was undertaken to

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39 WA Country Health (2007). *Engaging Rural Doctors*. Perth, Department of Health WA.

40 Rural Health West. (2007). "Rural Generalist Pathway, Western Australia." Retrieved 4 May, 2010, from <http://www.ruralhealthwest.com.au/go/support/workforce/sustainable-models/rural-generalist-pathway-western-australia>.

review existing and potential needs which would shape the training model for local regions. The audit identified:

- the existence of low entry rates into general procedural medicine and the need to establish a rural generalist pathway based in regional centres
- the decline in the rural procedural workforce that will accelerate with the ageing of the workforce. Moreover, fewer graduates are choosing to practise procedural medicine
- that in WA there is unanimous support for the RCS model which has the basic infrastructure in most of the major rural centres and provides local training
- that some regional centres in WA are well placed to accept supernumerary procedural training placements. These centres provide the volume of work to maintain good exposure for trainees in obtaining their core training and advanced rural skills program and experienced GP proceduralists and specialists who are willing to teach.

It was concluded that a model for the Rural Generalist Pathway in Western Australia needs to be promoted, responsive, resourced and marketed appropriately. This model would be designed for maximum flexibility of entry points to accommodate a variety of medical backgrounds and experiences but also enable an exit into other training programs. It was proposed to commence the WA Rural Generalist Pathway in 2009 with development of the training pathway and sites to occur in 2008.

- The *Royal Australian College of General Practitioners (RACGP)* in its submission to the Western Australian Government concerning the establishment of a Rural Generalist Pathway<sup>41</sup> supported the adoption of a generalist pathway as long as it was integrated within the RACGP framework. RACGP argued that an appropriate model for WA would include:
  - adopting rural general practice as its main focus because 'rural generalism' lacks definition relevant to medical specialty status and is not as appropriate to the WA context as it is to Queensland Health
  - adopting the RACGP definition of rural general practice and recognise the RACGP as standards setter for the training pathway
  - working with the RACGP's National Rural Faculty to establish a mentoring network to ensure continuity of encouragement and support for individual medical students with an interest in rural general practice through their postgraduate hospital years and into GP vocational training
  - ensuring sufficient investment in rural GP teaching practice capacity and remuneration for rural GPs to provide educational and mentoring services to maximise the Rural Generalist Training Pathway model's chances of success
  - curricular articulation between the levels of GP learning i.e. undergraduate, post-graduate, vocational and post-vocational – the RACGP curriculum could be used as the basis for this, as it already covers all four levels
  - integrating the RACGP general practice curriculum for pre-vocational doctors into the core curriculum proposed for the WACHS rural generalist pathway
  - ensuring the maintenance and accreditation of Advanced Rural Skills Posts in WA Country Health Service (WACHS) training to FARGP level and accessible via GP vocational training
  - replacing the differentiation between procedural and non-procedural GPs as an output of the model with a distinction between vocationally qualified GPs and GPs with training and qualifications in advanced skills
  - incorporating the richness of a GP career path beyond vocational fellowship as a 'lighthouse' incentive for students and graduates interested in participating in the WA rural training pathway

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41 Royal Australian College of General Practitioners (2007). WA Rural Generalist Pathway – A Submission by the Royal Australian College of General Practitioners.

- ensuring the RACGP's FARGP is the visionary focus of the WA rural training model, as it combines a career path in general practice beyond vocational fellowship with a dedicated rural qualification in general practice that is accessible via a vocational training pathway.
  - utilising the Regional Training Provider (WAGPET) as the focal axis for delivery of WA's rural training model
  - adopting the RACGP's MAP and incorporate FRACGP IMG mentors into the WA rural training model to extend its support to WA's rural IMG population.
- A number of other strategies have been introduced in WA to promote interest in rural and general practice and supplement the workforce in areas experiencing significant gaps. *The Annual Report for 2008/09 of WA Country Health*<sup>42</sup> reported that:
    - community residency and rural generalist programs with increased rural and community rotations had increased the number of medical interns from 190 to 235
    - five new general physician training posts were established to take advantage of an interest in generalist internal medicine
    - the Rural Generalist Pathway would continue to develop with additional posts created for junior doctors in Broome, Albany and Geraldton.
  - Under the *WA Country Health Operational Plan for 2009/2010*<sup>43</sup> a key Direction was Workforce Stability and excellence. Under this direction, an Action was specified as "to stabilise and skill the workforce and provide a safe and supportive workplace. A deliverable specified for this Action was to deploy 20 Rural Generalist year one doctors.
  - The *Royal Australasian College of Surgeons (RACS)* published a position paper on the training for GP Surgical Proceduralists<sup>44</sup>. This paper argued that a good surgical service should be characterised by timely access to the appropriate service and that where surgical services cannot be provided by a fully trained surgeon, the doctor providing the surgery, in most cases a GP, is equipped with the skills and training to the level of the surgical service that is required. RACS noted that GPs in rural communities undertaking procedural work need strong linkages with the surgeons and regional hospitals to which they naturally refer. Their surgical skills will be site-specific and need to be considered in the context of the infrastructure available including the physical resources (hospital, surgery facility) as well as the professional support available (anaesthetic and medical services, nursing and allied health). The paper proposed components of GP surgical procedural training for GPs intending to practise in rural and remote locations. These included:
    - a general curriculum which can be achieved in a 1 year training program
    - identification and accreditation by the RACGP or ACRRM of suitable training posts with supervision provided by a fully trained surgeon
    - facilitation to attend specific courses which will be of value to the trainee, eg. EMST, CCrISP, a modified ASSET surgical skills course, risk management courses
    - recognition that GP surgical procedural practice is site-specific and other more complex skills may need to be taught to selected GPs. This pathway would require close cooperation between the surgeon(s) who will ultimately oversee the GP proceduralist and the surgeons at the facility providing the training
    - recognition that the GP surgical proceduralist is an extension of the total surgical care to that community and therefore that strong linkages need to be forged during the training period with the surgeon(s) with whom he/she will be working and who will be acting ultimately as supervisor(s)

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42 WA Country Health (2009). Annual Report 08/09 Part 4, Operations. Department of Health WA. Perth.

43 Department of Health WA (2009). WA Country Health Service Operational Plan 2009/10. Department of Health WA. Perth.

44 Royal Australasian College of Surgeons. (2007). "Training for GP Surgical Proceduralists." Retrieved 8 May, 2010, from [http://www.surgeons.org/AM/Template.cfm?Section=Guidelines\\_and\\_position\\_papers&template=/CM/ContentDisplay.cfm&ContentID=22191](http://www.surgeons.org/AM/Template.cfm?Section=Guidelines_and_position_papers&template=/CM/ContentDisplay.cfm&ContentID=22191).



- funding necessary for the training of the GP proceduralist will need to cover all aspects of the training program, the trainers and the supporting courses
- agreement between the RACS, the RACGP and ACRRM as to a common pathway of training and accreditation, CPD, audit and procedural review.

The RACS Position Statement incorporates a curriculum that aims to promote expertise in:

- diagnosis and management of surgical illnesses
- diagnosis and management of trauma
- common surgical conditions and appropriate surgical procedures.

The Specialist Medical Colleges have a significant interest in the development of rural generalism through the expansion of rural general practitioner roles in procedural care. The researchers for this review project consulted the Colleges most frequently cited in documentation about rural general practice training in Australia. The detailed responses from the Colleges are reported elsewhere in this Review.

## 10.6 Scope of practice

One critical issue with respect to rural generalists is scope of practice. International research suggests that in rural areas the scope of practice of primary care physicians is extremely broad, covering many areas of primary health care and procedural medicine. Idaho (US) practicing rural family physicians, for instance reported a broad scope of practice including obstetric services in the areas of prenatal care (57.6%) vaginal delivery (52.2%) and Caesarian sections (37.0%); other operating room services (43.5%); esophagogastroduodenoscopy (EGD) or colonoscopy services (22.5%); emergency room coverage (48.9%); inpatient admissions (88.9%); mental health services (90.1%); nursing home services (88.0%); and supervision to midlevel care providers (72.5%)<sup>45</sup>. Younger, employed and female rural family medicine physicians are important subgroups for further study.

A US study<sup>46</sup> which surveyed family physicians who had completed post fellowship training in family medicine obstetrics and maternal-child health, found that a majority of family physicians cared for high-risk pregnancy patients and performed operative procedures related to pregnancy.

The requirement for an extended scope of practice appears to be greater where disadvantaged communities are served. The general lack of specialist medical capacity in rural areas appears to be exacerbated with respect to the provision of services to indigenous, minority and disadvantaged communities. A study of rural American Indian health clinics in Montana and New Mexico (US) found that substantial proportions of rural Indian clinic providers in both states reported fair or poor non-emergent specialty service access for their patients. Montana's rural Indian clinic providers reported poorer patient access to specialty care than rural non-Indian clinic providers, while New Mexico's rural Indian and non-Indian providers reported comparable access<sup>47</sup>.

## 10.7 Requirement for advanced skills training

The literature confirmed that there is clearly a requirement for the provision of appropriate training for rural general practitioners with procedural skills. For example a study of the emergency medicine training demographics of physicians working in rural and regional emergency departments in south-western Ontario found that the majority (70.1%) of physicians had no formal emergency medicine training. Most were members of the College of Family Physicians of Canada (CCFPs). The minimum qualification to work in the surveyed EDs was a CCFP in 8 EDs (32.0%) and a CCFP with Advanced Cardiac and Trauma Resuscitation Courses (ACLS and

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45 Baker, E., D. Schmitz, T. Epperly, A. Nukui and C. M. Miller. "Rural Idaho family physicians' scope of practice." *J Rural Health* 26(1):85-89.

46 Chang Pecci, C., L. Leeman and J. Wilkinson. 2008. "Family medicine obstetrics fellowship graduates: training and post-fellowship experience." *Fam Med* 40(5):326-332.

47 Baldwin, L. M., W. B. Hollow, S. Casey, L. G. Hart, E. H. Larson, K. Moore, E. Lewis, C. H. Andrilla and D. C. Grossman. 2008. "Access to specialty health care for rural American Indians in two states." *J Rural Health* 24(3):269-278.

ATLS) in 17 EDs (68.0%). None of the surveyed EDs required a CCFP(EM) or FRCP(EM) certification, even in population centres larger than 50 000<sup>48</sup>.

A further Canadian study<sup>49</sup> examined where family physicians learn the procedures they perform. The study found that for Canadian family physicians, procedural skill acquisition occurred across the learning continuum. The vast majority of respondents to a survey reported learning procedural skills in medical school or during family medicine residency training (91.1%), followed by the clinical practice setting (12.6%), then formal skills training (6.4%). Those in rural practice learned a relatively greater proportion of procedural skills through formal skills training.

In rural areas of the United States, emergency departments are often staffed by primary care physicians, in contrast to urban and suburban hospitals where ED coverage is usually provided by physicians who are residency-trained in emergency medicine. Lew, Fagnan *et al*<sup>50</sup>, examined the reasons and incentives for rural Oregon primary care physicians to cover the ED and their reported measures of confidence and priorities for additional training. They found that almost two fifths of surveyed primary care physicians in a rural practice-based research network provide ED coverage. These physicians had low levels of confidence and a desire for additional training in paediatric emergencies.

Rural areas in the United States have fewer physicians compared to urban areas, and rural emergency departments often rely on community or contracted providers for staffing. The emergency department workforce is composed of a variety of physician specialties and clinicians. An examination of non-emergency medicine-trained physician coverage in rural emergency departments<sup>51</sup> found that Board-certified emergency physicians provide 75% of all emergency department care, but only 48% for Medicare beneficiaries of the most rural of counties. The bulk of the remainder of emergency department care was largely provided by family physicians and general interns, with the percentage increasing with rurality. The likelihood of being seen by an emergency physician in the emergency department decreased 5-fold as rurality increases, while being seen by a family physician increased 7-fold.

In response to this perceived lack of advanced skills training in support of rural generalists, a number of initiatives were reported and mentoring and practical skills development identified as an important strategy in maintaining procedural skills. For example, Mavalankar, Callahan *et al*<sup>52</sup>, in a study of emergency obstetric care (EmOC) in rural India, found that being posted with a specialist anaesthesiologist and with a cooperative EmOC provider increased the likelihood that the MOs would provide anaesthesia. Medical officers who did not provide anaesthesia were more likely to have been posted with a nonperforming or uncooperative EmOC provider and were more likely to have low confidence in their ability to provide anaesthesia. Facilities were found to be under prepared to tackle emergency obstetric procedures.

Wetmore, Rivet *et al*<sup>53</sup> created a list of core and enhanced procedures required for family medicine training in Canada, utilising a Delphi technique. Participant physicians were asked to rate each of 158 procedures as to whether they would expect a graduate from a Canadian family practice training program to have learned and be capable of performing that procedure in their own community. In a second survey, participants were asked to verify the core and enhanced procedures lists produced from the first survey. Sixty-five core procedures and 15

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48 Bhimani, M., G. Dickie, S. McLeod and D. Kim. 2007. "Emergency medicine training demographics of physicians working in rural and regional southwestern Ontario emergency departments." *Cjem* 9(6):449-452.

49 Crutcher, R. A., O. Szafran, W. Woloschuk, R. G. Chaytors, D. A. Topps, P. W. Humphries and P. G. Norton. 2005. "Where Canadian family physicians learn procedural skills." *Fam Med* 37(7):491-495.

50 Lew, E., L. J. Fagnan, N. Mattek, J. Mahler and R. A. Lowe. 2009. "Emergency department coverage by primary care physicians in a rural practice-based research network: incentives, confidence, and training." *J Rural Health* 25(2):189-193.

51 Peterson, L. E., M. Doodoo, K. J. Bennett, A. Bazemore and R. L. Phillips, Jr. 2008. "Nonemergency medicine-trained physician coverage in rural emergency departments." *J Rural Health* 24(2):183-188.

52 Mavalankar, D., K. Callahan, V. Sriram, P. Singh and A. Desai. 2009. "Where there is no anesthetist--increasing capacity for emergency obstetric care in rural India: an evaluation of a pilot program to train general doctors." *Int J Gynaecol Obstet* 107(3):283-288.

53 Wetmore, S. J., C. Rivet, J. Tepper, S. Tatemichi, M. Donoff and P. Rainsberry. 2005. "Defining core procedure skills for Canadian family medicine training." *Can Fam Physician* 51:1364-1365.

enhanced procedures were identified in the surveys. More procedures were ranked on the core list and were performed by rural and small-town physicians than by urban physicians.

## 10.8 Education strategies to support rural practice

In many countries there are education strategies in place to enhance the attraction and retention of a rural medical workforce and to ensure that that workforce has the required skills to perform required tasks. The majority of Canadian medical schools, for instance, reported mandatory or elective rural medicine placement/learning experiences during undergraduate medical education, as well as Rural Family Medicine streams or programs as components of postgraduate medical education. The majority provide clinical traineeships to enhance clinical competencies in rural medicine as well as CME outreach programming, including the use of telehealth or distance learning technologies<sup>54</sup>. Similar programs operate within the United States and initiatives include recruitment and retention committees of rural community members; special rural-focused topics and events during the first three years of undergraduate medical education; and a required fourth-year, and a 16-week rural preceptorship through which students work with primary care physicians and conduct community-oriented primary care projects<sup>55</sup>.

Krupa, and Chan<sup>56</sup> examined Canadian rural family medicine residency programs, noting number of rural training programs and positions; months of rural exposure, degree of remoteness, and specialist support of rural communities within rural training programs. They found the number of rural training programs rose from one in 1973 to 12 in 2002. Most medical schools offer dedicated rural training streams. From 1989 to 2002, the number of rural residency positions quadrupled from 36 to 144; large jumps in capacity occurred from 1989 to 1991 and then from 1999 to 2001. Rural positions now represent 20% of all family medicine residency positions. Among rural programs, minimum rural exposure ranged from 4 to 12 months, and the median distance between rural training communities and referral sites ranged from 50 to 440 km (median 187 km). Rotations in communities with no hospital were mandatory in five of 12 rural programs, optional in five, and unavailable in two. The proportion of training communities used by rural programs that had family physicians only (ie, no immediate specialty backup) ranged from 0 to 78% (mean 44%). Most training communities (78%) used by rural programs had fewer than 10 000 residents. Four of 12 rural programs offered various specialty medicine rotations in small communities.

Some of the literature however argued that this has not gone far enough, particularly with respect to the preparation of rural proceduralists. For example, in a commentary article, Rosenblatt<sup>57</sup>, argued that U.S. medical schools, supported in large part by public funds, have a responsibility to ensure that the specialty choices and practice locations of their graduates meet the needs of the nation at large, as well as the rural and underserved communities in the regions they serve.

A number of initiatives were identified in the literature in relation to preparation of rural proceduralists. For example:

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54 Curran, V. R., L. Fleet, R. W. Pong, S. Bornstein, M. Jong, R. P. Strasser and G. Tesson. 2007. "A survey of rural medical education strategies throughout the medical education continuum in Canada." *Cah Sociol Demogr Med* 47(4):445-468.

55 Glasser, M., M. Hunsaker, K. Sweet, M. MacDowell and M. Meurer. 2008. "A comprehensive medical education program response to rural primary care needs." *Acad Med* 83(10):952-961. Heng, D., R. W. Pong, B. T. Chan, N. Degani, T. Crichton, J. Goertzen, W. McCready and J. Rourke. 2007. "Graduates of northern Ontario family medicine residency programs practise where they train." *Can J Rural Med* 12(3):146-152. Nash, L. R., M. M. Olson, J. W. Caskey and B. L. Thompson. 2008. "Outcomes of a Texas family medicine residency rural training track: 2000 through 2007." *Tex Med* 104(9):59-63. Rabinowitz, H. K., J. J. Diamond, F. W. Markham and J. R. Wortman. 2008. "Medical school programs to increase the rural physician supply: a systematic review and projected impact of widespread replication." *Acad Med* 83(3):235-243. Smucny, J., P. Beatty, W. Grant, T. Dennison and L. T. Wolff. 2005. "An evaluation of the Rural Medical Education Program of the State University Of New York Upstate Medical University, 1990-2003." *Acad Med* 80(8):733-738.

56 Krupa, L. K. and B. T. Chan. 2005. "Canadian rural family medicine training programs: growth and variation in recruitment." *Can Fam Physician* 51:852-853.

57 Rosenblatt R. A. "Commentary: do medical schools have a responsibility to train physicians to meet the needs of the public? The case of persistent rural physician shortages." *Acad Med* 85(4):572-574.

- a study by Doty, Zuckerman and Borgstrom<sup>58</sup> which described the extent to which general surgery residency training prepared future rural surgeons suggested a need for organisation and coordination among educational programs committed to training surgeons for rural practice. The creation of a consortium of general surgical residency programs with an interest in training rural surgeons was recommended as a useful first step in this process.
- in India, a comprehensive 16-week training program for medical officers on emergency obstetric care held in 2006 was successful in significantly improving the performance of rural facilities in delivering basic emergency obstetric care<sup>59</sup>.
- the Rural Physician Action Plan in Alberta (Canada) developed an Enrichment Program to assist physicians practising in rural Alberta communities to upgrade their existing skills or gain new skills<sup>60</sup>. The program aimed to provide a single point of entry to skills training that was individualised and based on the needs of rural physicians. Two experienced rural physicians were engaged as "skills brokers" to help rural physicians requesting additional skills training or upgrading to find the training they required. Each applicant was assigned a preceptor. Preceptors confirmed learning objectives with trainees, provided the required training in keeping with agreed-upon learning objectives, and ensured trainees were evaluated at the end of the training.
- a Canadian study<sup>61</sup> examined the experiences of care providers in 4 rural British Columbia communities that had lost or were at risk of losing their local maternity services. Care providers identified significant stressors related to the provision of maternity care services, including the development and maintenance of competency in the context of decreasing birth volume, the safety of local maternity care without caesarean section and the desire to balance women's needs with the realities of rural practice.

## 10.9 Organisational and policy initiatives

A number of initiatives are identified internationally, which seek to protect and extend the roles of rural generalists. These have involved the establishment of regulatory and accrediting bodies and the development of coalitions of interest amongst stakeholders. For example, Smith, Prideaux *et al*<sup>62</sup> described the processes associated with accreditation of the Australian College of Rural and Remote Medicine (ACRRM) as a standards and training provider, by the Australian Medical Council (AMC) in 2007. The project resulted in an innovative formative and summative assessment program that occurs throughout 4 years of vocational training, using reliable, valid and acceptable methods with educational impact. It is argued that the ACRRM assessment program breaks new ground for assessing rural and remote doctors in Australia, and provides new evidence regarding how a comprehensive and contemporary assessment system can work within a postgraduate medical setting. Subsequently, the Australian Government formally recognised rural and remote medicine as a generalist discipline under Medicare.

Nixon and Blattner<sup>63</sup> also described the process of establishing a professional body to generate a skilled generalist medical workforce in NZ rural hospitals. This process focused on establishing a Branch Advisory Body to the Royal New Zealand College of General Practitioners and seeking Medical Council of NZ recognition of rural hospital medicine as a new scope of practice.

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58 Doty, B., R. Zuckerman and D. Borgstrom. 2009. "Are general surgery residency programs likely to prepare future rural surgeons?" *J Surg Educ* 66(2):74-79.

59 Evans CL, Maine D, McCloskey L, Feeley FG & Sanghvi H. 2009. Where there is no obstetrician – increasing capacity for emergency obstetric care in rural India: an evaluation of a pilot program to train general doctors. *Int. Journal of Gynaecology & Obstetrics*. 107(3): 277-282.

60 Gorsche, R. and J. Hnatuik. 2006. "Additional skills training for rural physicians. Alberta's rural physician action plan." *Can Fam Physician* 52:601-604.

61 Grzybowski, S., J. Kornelsen and E. Cooper. 2007. "Rural maternity care services under stress: the experiences of providers." *Can J Rural Med* 12(2):89-94.

62 Smith, J. D., D. Prideaux, C. L. Wolfe, T. J. Wilkinson, T. Sen Gupta, D. E. DeWitt, P. Worley, R. B. Hays and M. Cowie. 2007. "Developing the accredited postgraduate assessment program for Fellowship of the Australian College of Rural and Remote Medicine." *Rural Remote Health* 7(4):805

63 Nixon, G. and K. Blattner. 2007. "Rural hospital medicine in New Zealand: vocational registration and the recognition of a new scope of practice." *N Z Med J* 120(1259):U2654.

However. Lockyer and Norton<sup>64</sup> noted that efforts to increase the availability of training positions, standardise training and obtain national recognition for family physicians in Canada who wished to practice anaesthesia, had stalled. They proposed that the critical aspects of successful intersectoral work, namely: involvement by key stakeholders; the development of decision-making mechanisms; clearly defined objectives, roles and responsibilities; official support and legitimisation from participating organisations and adequate resources for partnership building, are required to bring about an effective Canadian rural family medicine anaesthesiology practice.

### 10.10 Conclusion

Despite such setbacks, it is clear from the literature that there are a number of approaches to addressing the rural doctor shortage that have reported success. It is also clear that most rural communities cannot sustain specialist services and have to rely on non-specialist doctors practising advanced procedural skills and while the literature indicated that rural doctors face barriers to maintaining advanced procedural skills, these can in part be overcome by targeted rural skills training programs, incentives that reflect remoteness of practice, and tailored vocational support.

Dedicated rural training programs are reported to be positively associated with recruitment and retention of rural doctors.

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64 Lockyer, J. and P. Norton. 2005. "An analysis of the development of a successful medical collaboration to create and sustain family physician anaesthesiology capacity in rural Canada." *Aust J Rural Health* 13(3):178-182.

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