

The rural generalist: a new generation of health professionals providing the rural medical workforce the bush needs

Dan Manahan¹, Tarun Sen Gupta¹, Denis Lennox¹, Natalie Taylor¹, Christian Rowan¹, Dale Hanson¹, Andrew McKenzie¹, James Telfer¹, Leanne Browning¹

¹Rural Generalist Pathway, Queensland Health

Dr Dan Manahan is a graduate from The University of Queensland. Dan undertook his studies with the assistance of a Queensland Health Rural Scholarship and commenced clinical practice in Rockhampton where he completed his internship. He then moved to Emerald in central Queensland; it was during this time he experienced the characters, practitioners, patients and friends who dramatically influenced his choosing of a career as a rural generalist.

After time in Goondiwindi that further cemented his rural vocation, he relocated to Brisbane for advanced skills training where he obtained obstetrics, anaesthetics and surgical credentials and married Jacinta, a city slicker prepared to leap into rural life. Dan and Jacinta moved to Stanthorpe in 1996 and have settled there, raising four children.

In combination, Dan manages his current significant role as Medical Superintendent at Stanthorpe with his rural generalist advisor role while maintaining his continuing professional education, recently completing an external Diploma in Medical Sonography. Dan is passionate about both developing and facilitating medical education and training opportunities for medical officers across rural and remote Queensland.

Abstract/overview

Rural generalist medicine was recognised in Queensland as a medical discipline of specialist equivalence in 2008. Since the introduction of the career pathway in 2007, approximately 140 trainees have commenced training on this education continuum to rural generalist status.

The Rural Generalist Pathway—which includes a challenging prevocational start to the career, the opportunity to specialise in a procedural skill or skills of interest and obtain general practice vocational training in a rural setting—is certainly proving an attractive choice for those searching for a challenging and varied career.

Although currently a Queensland phenomenon, this unique and exciting career pathway continues to generate increased interest and enthusiasm across all Australian states and territories now wishing to join this new wave of generalist practice. This new generation of health professionals for a new generation of services will, in turn, provide the rural medical workforce the bush needs.

As the number of trainees increases, so in turn does the competition for advanced skills training posts. The pursuit to identify, accredit and develop not only a range, but an appropriate number of advanced skills training posts is now a major focus and challenge to the ongoing expansion of the training pathway. A collaborative approach to identifying posts, selecting appropriate applicants via an open merit selection process and providing ongoing orientation and support throughout the advanced skills training year is currently a major state wide project of the pathway.

A significant outcome of the pathway currently being researched concerns the advanced skill(s) being pursued including identifying how many trainees go on to use the skills, in what location(s), and for how long.

This paper will identify and report on the outcomes of the research into the advanced skills being pursued and used by rural generalists in Queensland and the new collaborative state wide approach to securing, selecting and supporting advanced skills trainees. It will also outline applicability of the concept of the rural generalist in other jurisdictions, and perhaps in other disciplines.

Background

Rural generalist (RG) doctors have been practising for many years in Queensland and Australia. However, in recent times a number of forces have seen a reduction in the number and scope of practice of doctors in rural Queensland consistent with other reported workforce trends.¹

The Queensland Health Rural Generalist Pathway (RGP) commenced in 2007 with a goal to provide medical officers with an interest in rural medicine, including hospital based practice, with an advanced skill suitable to a rural location.

While conduits to rural practice have been trialled, retention in rural areas has been poor. The RGP intends to facilitate existing training pathways and provide vocational training opportunities within Queensland Health (QH) rural hospitals. This process recognises that QH rural hospitals have been accredited training sites in an ad hoc way in the past and, most importantly, that QH hospitals are wonderful training opportunities largely underutilised. These issues were discussed and debated at a multidisciplinary meeting in 2005 in Roma with the outcomes becoming known as the Roma Agreement.²

‘Rural generalist’ is a term with different meanings. In a general way, the term refers to a rural located doctor, supplying a broad section of services including a high percentage of specialised services such as emergency medicine, obstetrics, or anaesthesia. In Australia, such doctors will now usually possess a relevant Fellowship qualification (FACRRM, FARGP or FRACGP) or a combination of these. The term ‘rural generalist’ also has a specific meaning within Queensland Health.

Rural generalists in Queensland Health

The Roma Agreement led to the concept of a rural generalist as a rural medical practitioner who is credentialed to serve in:

- hospital based and community based primary medical practice, and
- hospital based secondary medical practice:
 - in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics, and surgery) AND
 - without supervision of a specialist medical practitioner in the relevant disciplines
- and possibly hospital and community based public health practice—particularly in remote and indigenous communities

The Queensland Health Rural Generalist Pathway (RGP) was developed as a training pathway for rural generalist trainees.³

Important industrial developments included development of the concept of a rural generalist senior medical officer (SMO) as an industrially defined classification which has remuneration advantage in a subset of hospital positions in rural Queensland hospitals. A rural generalist full time SMO will have qualified as a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) or Fellow in Advanced Rural General Practice (FARGP) and have an advanced skill (AS) which matches the position description for the hospital they work in.

Other relevant principles were enunciated to develop an attractive training pathway with industrial recognition:

- a rural generalist with the right to private practice will be advantaged if providing specialised services
- a rural generalist providing visiting medical officer (VMO) services will be financially advantaged if rostered for obstetrics, anaesthesia, or surgery services.
- non-rural generalists (generally non-procedural or rural doctors without Fellowship qualifications) are remunerated at a lower rate.
- a rural generalist trainee in an SMO post during vocational training will be termed a rural generalist provisional fellow if they are within the RGP and or have had a successful prevocational assessment, and have completed their AS and are able to practice their AS within the position.

Different jurisdictions may have different uses of the term ‘rural generalists’ in different settings. The above terminology applies within Queensland Health positions for senior medical officer, medical superintendent /

medical officer with right to private practice, visiting medical officer, and the registrar training posts. Developing nomenclature to distinguish the general concept of a rural generalist doctor from the specific industrial recognition of a rural generalist may be useful to avoid confusion in the future.

The Queensland Health Rural Generalist Pathway

The Rural Generalist Pathway is essentially a fast track to rural practice with a vocational qualification which is either FACRRM or FARGP or combination. FRACGP alone has been determined as not a suitable endpoint as the 3-year qualification, whilst an excellent general practice qualification, does not have the additional advanced skills year that both FACRRM and FARGP include. Thus the QH RGP requires the four year FACRRM or FARGP.

The vocational training uses the existing structures so as not to reinvent the wheel. These include:

- the Medical Board requirements of Internship
- the college or Joint Consultative Committee (JCC) based requirements for an advanced skills year
- the college requirements for vocational training delivered by Regional Training Providers or the Remote Vocational Training Scheme^{4,5}
- accredited posts for training
- accredited supervisors for training
- college examination processes
- and once Fellowship is achieved professional development relevant to the respective College and Advanced Skill.

In addition, ACRRM, as the lead college in setting the rural generalist standards, have specified the additional requirements:

- the Prevocational Assessment in Post Graduate Years (PGY) 1 and 2
- terms in anaesthetics, obstetrics, and paediatrics in PGY1 and 2
- RG Workshops in PGY 1 and 2
- Vocational Indicative Planning (VIP) throughout the RGP but most intensely in PGY1 and 2 as a means of vocational counsel and support
- with a satisfactory Prevocational Assessment and AS, opportunity to train in a QH facility as a Provisional Fellow RG SMO after competitive merit-based selection
- and thus to access improved training and remuneration packages in what is hoped to be a satisfying and sustainable long term career option within QH.

The advantages of the program in this current era are that it:

- addresses lack of career paths for Queensland rural hospital and rural medical careers
- may suit the new age of medical practitioners—Gen X and Y e.g. salary rather than a private business commitment increases flexibility, career flexibility, mobility, others
- PROVIDES a generalist career opportunity which may suit Gen X and Gen Y
- minimises need to move location for the trainee and family to one or two moves
- allows flexibility

- is a supported fast track path to procedural rural medical practice
- enables engagement with Queensland Health during training with improvements in attrition rates and satisfaction
- provides good remuneration for Provisional Fellows at near-specialist rates
- allows flexible working options once Fellowship is achieved
- allows opportunity to contribute to the QH organisation, education, clinical governance, management
- provides a mobile qualification—Fellows are vocationally registered as a GP anywhere in regional or metropolitan Australia
- allows an opportunity for regional outer metro relocation, e.g. as a Generalist in Emergency Medicine
- provides an opportunity for specialisation later, for example via recognition of prior learning.

Advanced skills training

Advanced skills (AS) training forms an important part of the pathway to becoming a rural generalist within Queensland Health.

It was clear from early in the evolution of the pathway that some advanced skills were obviously well aligned with rural generalist medicine in Queensland. These were disciplines already established within rural hospitals and had mature collegiate training pathways.

Where a maternity service existed, obstetrics and anaesthetics were needed to support this process. This meant operating theatres were required with operating nurses, equipment, and instruments and so surgical advanced skills marry well to these hospitals. Joint Consultative Committees (JCC) exist for these three core disciplines. Where no maternity service exists emergency medicine advanced skills provide a skill set to manage the infrequent events encountered in small rural communities and so emergency medicine is considered an important AS. Finally, the issues of Indigenous health inequities and the significant Indigenous communities in rural Queensland have ensured this is an important AS.

While these five advanced skills clearly defined themselves as vital AS in the Queensland Health context, other AS were expected to attract a smaller number of candidates. These included general medicine, paediatrics, mental health, and population health.

While other options have been suggested and requested, these are the core of current RG Advanced Skills available in the pathway. Requests for AS in echocardiology, intensive care medicine, and ophthalmology have been considered and, after consultation, not supported. The skills that can be achieved in some of these other areas such as intensive care are undeniable yet the applicability to everyday use in rural practice were considered either less relevant compared to other AS or potentially an extension of another AS—ophthalmology as part of surgery or general medicine, and echocardiography as part of general medicine.

Working principles to define an AS post within Queensland Health included the following:

- that it can and will appear on a position description in a rural hospital job
- that a college will provide a rural based curriculum
- that a college will provide accreditation of posts, supervisors, and professional development
- that the Scope of Practice for the AS is appropriate to a rural hospital
- that credentialing committees will provide credentialing for the AS
- support for the AS by the trainee's training provider

- and that the State Recognition of Practice Committee (SRPC) agrees that the AS is appropriate to the RG qualification.

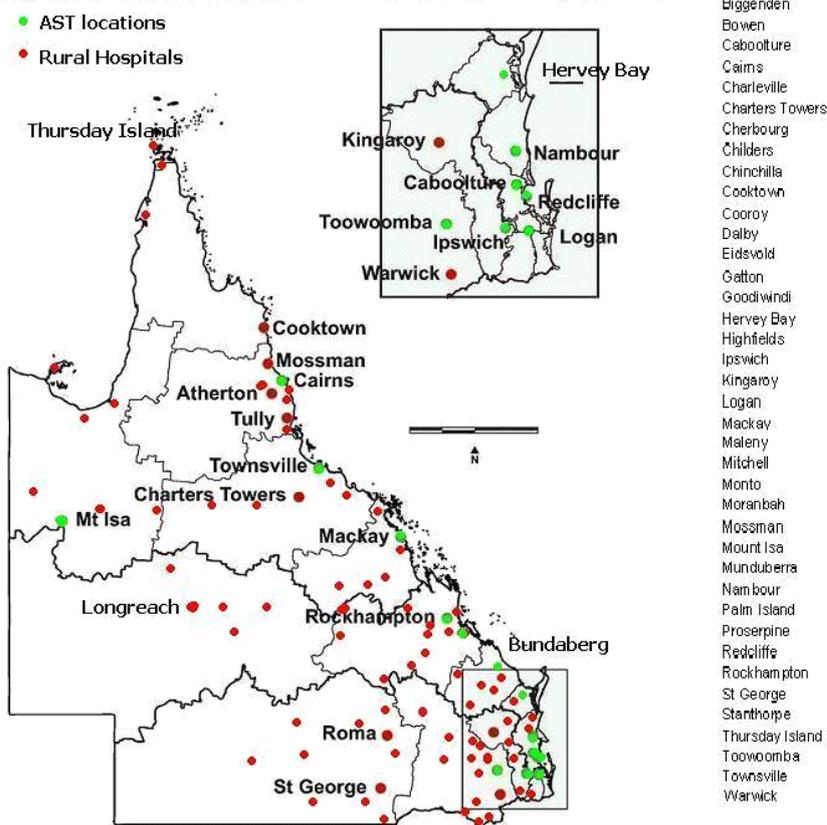
The SRPC consists of QH management and RGs, college representatives including ACRRM and RACGP and Union representatives. The SRPC sets standards and reviews cases as needed to ensure rural generalist doctors are trained to the appropriate standard and paid at the appropriate remuneration scale. This includes consideration of appropriateness of AS.

The industrial flow-ons from the RG standards carry significant cost benefit to the RG doctor. The cost to QH financially is difficult to measure as it balances a higher outlay against better local performance, more or maintenance of local services such as birthing, and the savings from travel and accommodation and the intangible lost income and productivity from patients leaving the rural locale and having metropolitan treatment. Thus the SRPC is closely aligned with the QH Medical Advisory Panel which has executive governance and decision making power.

Workforce implications

Many hospitals have incumbents who met the RG standards as defined by the SRPC. Many of these pioneering rural doctors are established and accomplished rural proceduralists who fashioned their own independent training pathway. The map of Queensland (Figure 1) indicates where QH hospitals suitable for RGs are located.

Queensland Health RGTP



- Ayr
- Bamaga
- Biggenden
- Bowen
- Caboolture
- Cairns
- Charleville
- Charters Towers
- Cherbourg
- Childers
- Chinchilla
- Cooktown
- Cooroy
- Dalby
- Eidsvold
- Getton
- Goodiwindi
- Hervey Bay
- Highfields
- Ipswich
- Kingaroy
- Logan
- Mackay
- Maleny
- Mitchell
- Monto
- Moranbah
- Mossman
- Mount Isa
- Mundubbera
- Nambour
- Palm Island
- Proserpine
- Redcliffe
- Rockhampton
- St George
- Stanthorpe
- Thursday Island
- Toowoomba
- Townsville
- Warwick

Locations in Qld which have hospitals and may attract RGs ●

● Prevac and AS

Figure 1 Rural generalist training locations

A significant number of doctors worked in these locations. However, attrition and vacancies still exist in many locations meaning many more RG doctors are needed to both meet the void and replace those leaving. Advertising for a RG anaesthetist or obstetrician has not yielded many successes in the past and the RGP hopes to provide a solution to this recruitment vacuum.

An example of the numbers has been modelled via the Queensland branch of the Australian and New Zealand College of Anaesthetists. The calculations would indicate an annual training requirement of 15-20 RG anaesthetists to maintain the required numbers to provide anaesthetic services in rural Queensland.

2011 placements for AS are as listed in Table 1 which also includes locations for training and reasons for not undertaking AST.

Table 1 Advanced skills trainees in Queensland for 2011

Emergency medicine	O&G	Anaesthetics	Surgery	Paediatrics	Total
7	6	6	1	2	22
4 female	5 female	4 female		1 female	14 female
3 male	1 male	2 male	1 male	1 male	8 male
		7 male Non-RG			Total 26 RG in PGY2 in 2011

Reasons for not progressing to AST	Locations for AS Training 2011		
Travel	Cairns	Rockhampton	Redcliffe
Private practice in rural location	Townsville	Gladstone	Toowoomba
Deferral to consider specialty	McKay	Hervey Bay	Ipswich
Deferral for personal reasons	Mt Isa	Caboolture	Logan

To date the outcomes of AS training have yielded 39 rurally based procedural doctors spanning Post Graduate Years 4-7.

Table 2 Trainees in procedural practice since the commencement of rural generalist training in 2006

Current 2011 postgraduate year	PGY4	PGY5 (PGY1 in '07)	PGY6	PGY7
Discipline (AS)				
Anaesthetics	2	5	6	5
Obstetrics	3	3	4	4
Emergency med	1	2	3	-
Other	-	1 x Gen Med	-	-
Total = 39	6	11	13	9

The issues of attrition are important to address. While some attrition is expected, staff involved in the RG pathway have explored ways of ways of reducing it. Common reasons cited for leaving the RGP after the Advanced Skills year, are consistent with other reports on the interplay of factors involved in determining rural workforce⁵⁻⁸ and include:

- desire to pursue a specialty
- partner needs to be in larger centre
- wish to remain regional or metropolitan for other personal social reasons
- partner a doctor who is on a specialist program
- liked a regional centre and have bought property
- liked a regional centre and family settled into school
- does not want to be in rural or remote locale.

Management plans to reduce attrition include:

- vocational Indicative Plans outlining intention to work rural and use AS rurally
- clear advice that AS is not an entry to specialty practice
- engaging trainees in the AS year using workshops and mentors
- making the interview process for AS more robust
- providing advice on which AS are appropriate to which locations
- assisting with networking trainees with senior rural generalists
- leadership programs which engage trainees in the QH process.

By providing good VIPs, networking opportunities for RGP doctors with established RGs, mentoring, workshoping, and liaison with RTPs, the usual outcome is not attrition but a trainee with a solid plan for their training after AS year. Most doctors have a rural training plan and can follow it.

The AS training year is seen as pivotal in the provision of the correct mix of procedural doctors with the correct skills for the correct locations. However, solid data on needs is difficult to obtain. Vacancy lists detail unfilled positions yet some posts are filled with proceduralists in one discipline while another is required. Relief staff on contracts have varied skill mix. And often, the staff establishment numbers are below those needed to maintain procedural practice in an era of intense standard reviews, credentials, patient safety, and fatigue risk minimisation. Further there are hopes of increasing services with options to reopen some birthing units.

Despite the lack of strong data on rural procedural needs, work is being undertaken. The engagement of the specialty colleges has been a highlight. QH has marketed the RGP as providing high quality RGs across a range of disciplines. As a means to provide quality training in AS and to manage potential bottlenecks in AS training, QH instigated Consultative Committees in the major disciplines.

Currently consultative committees are functioning for:

- emergency medicine
- obstetrics
- surgery
- anaesthetics

and interest is strong in paediatrics and mental health.

Consultative committees have representation from the specialty colleges, RGP, experienced RGs, QH, ACCRM, and other groups. The intention of these consultative committees is to achieve:

- maximum competence and capability of rural generalist AS trainees
- maximum training opportunities in QH hospitals for AS training
- effective and efficient management of selection and placement of trainees
- AS posts which operate in the best interests of trainees and training services
- processes for MOPS for successful AS trainees
- best value from the investments in training
- educational outcomes using the best available pedagogical evidence.

Outcomes of the consultative process which have evolved through consultation include:

- engagement by specialists in the RGP
- engagement of department directors and training coordinators across the state in this process

- assistance in accrediting posts for AS training
- review of curriculum and its relevance to RG practice in Qld
- ensuring robust examination and completion criteria exist
- where possible, developing processes which are uniform across the AS disciplines
- assistance in developing a centralised AS application process.

The specialty colleges' willingness to engage in this process and provide quality outcomes has been noteworthy. Discussions have been robust but the desire of specialty colleges to have high quality rural generalists providing procedural services to rural patients has been clear and paramount.

The Queensland Health specialty consultative committees are ongoing. While much work is needed in order to garner agreement and operationalise the outcomes, the program has had a sound start and is starting to make an impact on the sustainability of rural medical workforce.

Conclusion

While the program has had considerable early success and has been supported by the profession, the future holds a number of challenges which include:

- managing and maintaining the networks
- marketing to a range of stakeholders such as:
 - trainees, ensuring they know this is a competitive process
 - existing rural generalists who may know best where the needs are
 - training hospitals and their specialist directors and trainers
 - the Regional Training Providers and Remote Vocational Training Scheme
 - the specialty colleges via consultative committees; state or tripartite
 - hospital executives holding funding and governance roles
 - interstate colleagues via journal articles, presentations, consultation
 - and other markets as they arise (and they do)
- providing the right number of high quality AS placements
- developing a needs analysis tool for AS numbers and locations
- developing a standard and centralised placement process for AS
- ensuring MOPS appropriate to the AS numbers
- developing clever ways of providing meaningful MOPS for AS
- maintaining a commitment to rural generalism across the QH organisation
- other challenges that we are yet to discover.

In addition, the QH RGP has seen much interstate interest. The program is currently engaged with the Northern Territory with plans to run a workshop in Darwin in 2011, and has hosted delegations from a number of states.

Queensland Health's Rural Generalist Pathway provides a model to blend a training program with a career pathway and industrial recognition in an attractive, incentive-based strategy to provide a sustainable medical workforce for rural Queensland. Scholarship holders may also be able to complete their return of service requirements while on the RG pathway. The program is managed by a dispersed team with a mix of backgrounds, skills and geographic locations. The model of rural generalism may be applicable for adoption in other jurisdictions, or in other health disciplines.

Acknowledgments

We wish to acknowledge the many people who have contributed to the success of the Rural Generalist Pathway: the RGP Team led by Denis Lennox; ACRRM, RACGP, the Regional Training Providers and the RVTS; rural generalists past and present for working in models of care that are evolving and contributing to this evolution; the vast number of supportive specialist colleagues and our patients who entrust us to their care and encourage us to help them in their rural communities.

References

1. Murray RB, Wronski I. When the tide goes out: health workforce in rural, remote and Indigenous communities. *Med J Aust* 2006; 185: 37-38. http://www.mja.com.au/public/issues/185_01_030706/mur10288_fm.html
2. A brief history of the Rural Generalist Pathway. <http://www.health.qld.gov.au/ruralgeneralist/content/history.asp> accessed January 2011
3. Rural Generalist Training. <http://www.health.qld.gov.au/ruralgeneralist/default.asp> accessed January 2011
4. Australian General Practice Training. <http://www.agpt.com.au/> accessed January 2011
5. The Remote Vocational Training Scheme. <http://www.rvts.org.au/> accessed January 2011
6. Eley D, Baker P. Does recruitment lead to retention? — Rural Clinical School training experiences and subsequent intern choices. *Rural Remote Health* [Internet] 2006; 6: 511. Epub 2006 Feb 3.
7. Magnus JH, Tollan A. Rural doctor recruitment: does medical education in a rural district recruit doctors to rural areas? *Med Educ* 1993;27:250-3.
8. Sen Gupta TK, Murray RB, McDonell A, et al. Rural internships for final year students: clinical experience, education and workforce. *Rural Remote Health* [Internet] 2008; 8: 827. Epub 2008 Feb 13.