



Post Fellowship Support Framework for Rural Doctors

A Queensland Pilot Project

February 2021

Version Control Information:

Printed copies of this document should not be relied upon as a current reference document. ALWAYS refer to the electronic copy for the latest version.



Document Date

11 February 2021

Authors

Dr Dilip Dhupelia, Director Medical and Clinical Services, Queensland Country Practice

Dr Ansmarie Van Erp, Director Strategic Business Development, Queensland Country Practice

Dr James Collins, Medical Administration Registrar, Queensland Country Practice

Ms Annette Butterworth, Principal Project Officer, Queensland Country Practice

Acknowledgements

This project was funded by the **Australian Government Department of Health**, as part of the Health Workforce Program, under grant opportunity G02747.

We thank **Health Workforce Queensland** for their collaboration on this project.

We are also grateful to all the respondents who contributed their valuable time to this project.

Copyright

Published by the State of Queensland (Queensland Health), February 2021



This document is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit creativecommons.org/licenses/by/3.0/au

© State of Queensland (Queensland Health) 2021

For more information contact:

Queensland Country Practice, Department of Health, GPO Box 48, Brisbane QLD 4001,

Email: QCP@health.qld.gov.au, phone + 61 7 3224 7825

Disclaimer

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Acronyms

ACRRM	Australian College of Rural and Remote Medicine
AMC	Australian Medical Council
AMS	Aboriginal Medical Service
AST	Advanced Skills Training
CPD	Continuing Professional Development
ED	Emergency Department
EMET	Emergency Medicine Education and Training
GP	General Practitioner
HHS	Hospital and Health Service
HWQ	Health Workforce Queensland
MMM	Modified Monash Model
MOPP	Medical Officer with right to Private Practice
MSPP	Medical Superintendent with right to Private Practice
NRGP	National Rural Generalist Pathway
PROMPT	Practical Obstetric Multi-Professional Training,
QCP	Queensland Country Practice
QRGP	Queensland Rural Generalist Pathway
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australasian College of Medical Administrators
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RGP	Rural Generalist Pathway
RTO	Regional Training Organisation
RWA	Rural Workforce Agency
SEIFA	Socio-Economic Indexes for Areas
SMO	Senior Medical Officer
SPSS	Statistical Package for the Social Sciences

Contents

Executive Summary	6
The Findings	7
1. Introduction.....	10
1.1 Queensland Context	12
1.2 Rationale for the Pilot Project.....	13
1.3 Objectives of the Jurisdictional Coordination Unit to support the National Rural Generalist Pathway	14
1.4 Scope.....	14
1.5 Structure of the Pilot Project.....	15
1.6. Pilot Project – Guiding Principles.....	17
Principle 1: Collaboration and coordination between primary and secondary care is vital	17
Principle 2: Rurally based career paths are recognised and valued.....	17
Principle 3: Job satisfaction is a critical element in working in rural and remote areas.....	17
Principle 4: The ability to attain advanced skills is supported to meet community needs	17
Principle 5: The ability to attain, maintain and upgrade procedural skills in hospitals or general practice is supported to meet community needs	18
Principle 6: The ability to work across hospital and general practice facilities to provide coordinated care is supported.....	18
Principle 7: Education and training needs are supported	18
Principle 8: Professional peer support is available	18
Principle 9: The viability of existing rural general practice is enhanced	18
Principle 10: Clinical Leadership capability is recognised, enhanced, encouraged and supported.....	18
2.0 Methodology	20
The qualitative component.....	20
The quantitative component	23
Data Analysis.....	25
3.0 Results	26
3.1 Connecting Primary and Secondary Care (Theme 1).....	28
Introduction.....	28
Results.....	31
3.2 Valuing a Rural Career (Theme 2)	46
Introduction.....	46
Results.....	47
Discussion	52
3.3 Supporting Training and Education (Theme 3)	56

Introduction.....	56
Results.....	58
Discussion	65
3.4 Valuing Rural General Practice (Theme 4).....	69
Introduction.....	69
Results.....	70
Discussion	73
4.0 Conclusion and Future Direction	76
References.....	78

Executive Summary

Practising rural medicine is widely regarded as both rewarding and challenging. Rural doctors provide a service of ineffable value to their communities and are often tasked with the responsibility of meeting their community's diverse healthcare needs without the ready access to medical specialties that metropolitan doctors take for granted. The service they provide spans all aspects of primary care, in-patient and emergency care and includes the acquisition of additional skills valuable in meeting the needs of their communities.

There is strong commitment evident across Government and Industry to support social and economic health across the rural sector, with access to healthcare highlighted as a critical factor for Australians living and working in rural communities. A safe and sustainable medical workforce, fit for rural practice, meeting the needs of rural communities, is a focus of strategic thinking and investment; as seen by the Commonwealth commitment to implement a National Rural Generalist Pathway. This takes time however with the training of a Rural Generalist requiring six years on average.

Queensland has a mature Rural Generalist pathway, attracting and supporting doctors to attain vocational general practice specialist qualification with advanced skills that support hospital and community-based primary and secondary practice. Advanced skills include but are not limited to recognised areas such as obstetrics, anaesthetics, emergency medicine and mental health. Additionally, the Queensland Industrial Framework for public sector employment recognises the value of Rural Generalist Medicine through improved remuneration for rural doctors who meet the State defined Discipline of Rural Generalist Medicine which defines a practitioner with competence and capability in scope of clinical practice which is influenced by the geographic and demographic characteristics of a community with limited accessibility to services available in larger populated regional and metropolitan centres. The scope of clinical practice granted is particularly broadened by reduced reliance upon secondary and tertiary medical services and the need to provide a medical service responsive to the health needs of a whole community – hence a 'generalist' scope of practice.

This project funded by the Australian Government undertook to identify opportunity to improve the Queensland program, build workforce involvement and alignment to the National implementation and support our current rural doctors. Queensland Country Practice (QCP) and Health Workforce Queensland (HWQ) have worked in partnership to establish a post fellowship support framework (the framework) that is intended to support and sustain post graduate rural doctors' practice integration, as National Rural Generalists across primary and secondary service domains through supported and rewarding models of engagement. The framework will address domains that include but are not limited to the clinical realm and focus on procedural practice and advanced skills training in the areas of need to the point that doctors can provide comprehensive general practice, emergency care and other specialised care in hospital and community settings as part of the a rural health care team.

As evidenced throughout this report there are a lot of good people working in rural communities and advocacy and stakeholder groups who have contributed to and championed the role of rural generalism in Queensland. It is also evident that there is more to be done to support and sustain the rural medical workforce beyond initial training. Creating and supporting high performing medical teams across geographical and employment boundaries is

the next challenge for the Queensland Program. This project outcome will guide the collaboration across Queensland to:

- Meet the National Rural Generalist Pathway model and implementation elements and plans
- Build sustainable workforce models and bespoke solutions that meet community needs
- Support doctors to practice and live rurally with career support to attain and maintain advanced skills
- Build a systemic culture of respect and support that elevates and recognises the role and value of a rural generalist in line with that given by their rural community.

Two themes were most strongly articulated and have been elevated as future priorities within the next phase:

- The business acumen necessary to run a high-volume low margin rural business presents significant attraction and retention challenges for rural doctors and service providers. Healthcare is an emotive people industry which strains and fatigues doctors who cannot simply turn away people who need them. It is more than a business and raises an ethical dichotomy for rural doctors
- The 'system' of healthcare needs to do more and consider innovative workforce and funding collaborations and innovations to make it easier for doctors to look after people and their communities. The quantity of rural practitioners across rural sectors creates fragility issues; it is not the practitioners who are fragile, it is the dependence on fragile workforce models that is the greatest challenge rural communities face to access medical care.

The Rural Generalist Program has been successful in Queensland; it is necessary to acknowledge and thank all those organisations and individuals who contributed to that success. It is also necessary to move beyond our current program and leverage the opportunity provided by the National Rural Generalist Pathway initiative to enrich the effectiveness and success through the next phase of development by increasing the number of rurally practicing primary care doctors and creating a community of medical practice workforce design.

The Findings

The findings validated the **10 Guiding Principles** considered important to incorporate into the Post Fellowship Support Framework and reflected **four key themes** (see Table 1). These themes provided a deeper understanding of the enabling and inhibitory factors associated with connecting primary and secondary care, valuing a rural career, supporting training and education in a rural area and valuing rural general practice.

Theme 1: Connecting Primary and Secondary Care	
Guiding Principle 1	<i>Collaboration and coordination between primary and secondary care is vital</i>
Guiding Principle 6	<i>The ability to work across hospital and general practice facilities to provide coordinated care is supported</i>
Guiding Principle 10	<i>Clinical leadership capability is recognised, enhanced, encouraged and supported</i>
Theme 2: Valuing a Rural Career	
Guiding Principle 2	<i>Rurally based career paths are valued</i>
Guiding Principle 3	<i>Job satisfaction is a critical element in working in rural and remote areas</i>
Theme 3: Supporting Training and Education in a Rural Area	
Guiding Principle 4	<i>The ability to attain advanced skills is supported to meet community needs</i>
Guiding Principle 5	<i>The ability to attain, maintain and upgrade procedural skills is supported to meet community needs</i>
Guiding Principle 7	<i>Education and training needs are supported</i>
Guiding Principle 8	<i>Professional peer support is respected, valued and available</i>
Theme 4: Valuing Rural General Practice	
Guiding Principle 9	<i>The viability of existing rural general practice is enhanced</i>

Table 1: Key Themes

The findings demonstrated a generally positive level of interest in working across both general practice / Aboriginal Medical Service (AMS) and hospital settings amongst rural doctors. However, favourable conditions would need to be achieved and more support would need to be provided for rural doctors to meet the NRGPs endpoints. The findings also demonstrated that while rural careers can be satisfying, job satisfaction was frequently impacted by increasingly voluminous and complex workloads.

A strong sense of value for training and education was reflected in the results, but it was also often reported that reasonable access to time away to undertake training was difficult and expensive to complete. Doing so required the doctor to arrange for and pay another doctor to cover their practice during these absences and to absorb the loss of revenue when doctors are not working in their practice. It was also reported that subspecialisation and onerous credentialing processes were making it more difficult for doctors to obtain, utilise and maintain additional skills training. As practice scope narrowed, doctors were unable to work to full scope, experienced de-skilling and decreased job satisfaction.

The findings also highlighted that general practice viability has changed over the years and that community expectation and need for bulk billing Medicare payment models presents fiscal and business viability issues for General Practice business operators. A strong theme that emerged was the need for rural doctors to have stronger business management skills to maintain viable rural practices, a skill that is not taught during their training and, more often than not, is learnt on an ad hoc basis.

Utilising the findings from this pilot project, **four foundational Pillars** were identified to guide the design and development of a **Post Fellowship Support Framework** for all rural doctors. The findings demonstrated that the framework should be underpinned by activities to foster connecting primary and secondary healthcare, valuing a rural career, supporting training and education and valuing rural general practice. Doing so will enable the development of a framework that optimally supports current and aspiring public and private rural doctors, working across primary and secondary healthcare settings, to meet the NRGF endpoint. Preliminary functions and actions required for the framework have been outlined in this report and building the full-scale framework will be progressed during the next phase when the Coordination Unit and its functions are expanded further.

This report demonstrates that the development and streamlining of a structured post fellowship support capability is vital in order to build a strong, sustainable and skilled medical workforce to meet the needs and expectations of rural and remote communities.

1. Introduction

Under the leadership of Australia's inaugural Rural Health Commissioner, Emeritus Professor Paul Worley, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) came together at Collingrove Homestead in the Barossa Valley and agreed on the definition of a 'Rural Generalist' as:

"a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural health care team."

This definition became known as the **Collingrove Agreement**, described in the National Rural Generalist Taskforce Advice paper [1]. The RACGP and ACRRM have since been tasked to work with the Australian Medical Council (AMC) and the Medical Board of Australia to obtain national recognition of the Rural Generalist discipline.

The service that rural doctors provide is often the only access rural and remote communities have to specialised services. The intention of recognising Rural Generalists as an endorsed title and a specialised field within general practice is to acknowledge the advanced skillset that rural doctors require to manage the complex medical challenges in rural and remote communities. Professionally recognising rural generalism as a specialisation and offering national recognition of that specialisation makes rural practice more attractive to both enter into and to remain in; and it also contributes to the ongoing quality assurance of rural medical services. As an educational framework, the National Rural Generalist Pathway (NRGP) provides a basis for considering recognition of prior learning and offers lateral (post-graduate) entry options into Rural Generalism. As such, it provides a workforce strategy to meet the health care needs of people living in rural communities now and into the future and to address the current maldistribution of the medical workforce in rural and remote locations.

As an initiative of the Australian Government Department of Health, the NRGP intends to provide a coordinated, efficient medical training pathway (see Figure 1), with nationally recognised skills, to deliver Rural Generalists able to practise quality healthcare capable of meeting the needs of rural, remote and regional communities. As a workforce strategy, the NRGP makes rural practice more attractive by supporting aspiring and existing Rural Generalists to achieve specialisation that is nationally recognised [1]. It also contributes to addressing the medical workforce maldistribution across Australia providing doctors with the right skills, in the right place, at the right time by professionally and financially recognising the value of doctors who provide Rural Generalist practice in rural and remote communities.

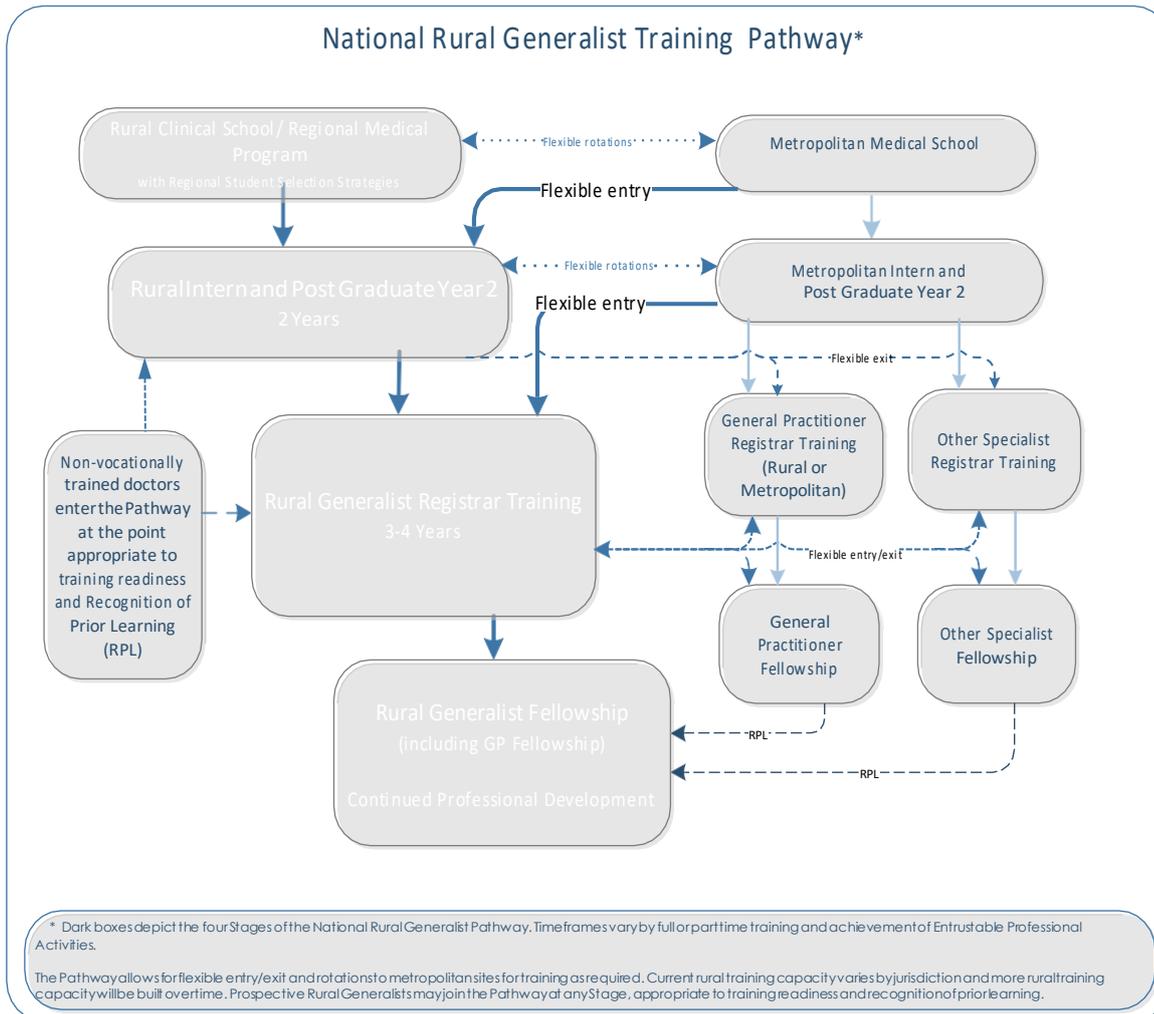


Figure 1: National Rural Generalist Pathway

To support the foundations for the future NRG, the Australian Government Department of Health provided grant funding to support the establishment of Jurisdictional Coordination Units.

In Queensland, the Coordination Unit will assist with practice recognition and workforce sustainability across public and private sectors; effectively coordinating the integration of service models that support the coordinated implementation of the NRG. The Jurisdictional Coordination Units are expected to work collaboratively with key sector stakeholders to improve workforce supply, achieving this by coordinating the training pipeline for Rural Generalists and developing a strong link between hospital and primary care training. Specifically, Jurisdictional Coordination Units will help to facilitate the transition of Rural Generalist trainees through the various educational and training components for the first six years of postgraduate training.

In Queensland, the grant funding was utilised to conduct a pilot project to investigate what is needed to support all rural medical practitioners who have achieved Fellowship, and who are undertaking or aspiring to undertake the training necessary to meet the Collingrove Agreement Rural Generalist definition. The pilot project was conducted in 2020 over a six-month period. The findings from the pilot project are provided in this report.

The findings are considered vitally important in informing a Post Fellowship Support Framework for rural doctors working in either private or public settings. It is anticipated that the pilot project will facilitate a seamless segue into designing and developing a Post Fellowship Support Model to support optimal implementation of the NRGF.

1.1 Queensland Context

The implementation of a Rural Generalist Pathway (RGP) is well understood in Queensland. Between 2001 and 2004 Queensland experienced an uncertain supply of both Australian and overseas trained doctors. This led to critical vacancies across Queensland with rural areas impacted most significantly. Strategic planning efforts were initiated, and an important meeting, held in Roma in 2005, resulted in the birth of the Queensland Rural Generalist Pathway (QRGP). The intended outcome of the Roma meeting was ***“to develop and sustain an integrated service and training program to form a career pathway supplying the rural generalist workforce that the bush needs.”***

The QRGP was underpinned by four independent pillars:

1. State recognition of the discipline of Rural Generalist Medicine
2. Valuing the practice of Rural Generalist Medicine (addressing the remuneration)
3. A Rural Generalist Training Pathway (an established training line)
4. Workforce redesign (incorporating rural generalist service redesign).

Queensland rapidly developed the requisite industrial reform and put into place the necessary policies to enable the first QRGP intake of trainees in 2007. From the initial annual intake of 30 trainees, training positions slowly increased to the current intake of 70 to 80 trainees per annum. This expansion included a shift from entry into the pathway restricted to interns only, to accommodating entry from postgraduate doctors and widening the opportunities to develop advanced skills. Since the first intake of trainees graduated, Queensland has seen a very rapid decline in its critical medical vacancies in rural areas.

While the QRGP was designed to address both primary and secondary care for rural communities, its most immediate impact was to significantly address workforce shortages in the public sector rural hospital system. The full strategic intent was further developed following the realisation of post fellowship Rural Generalists from 2010 with the development and support for workforce roles that include primary care and general practice through redesign of services (in keeping with pillar 4) which has led to a steady participation and increase in blended roles, where doctors work across primary, secondary and emergency care.

The QRGP currently supports 340 active Rural Generalist trainees in various stages of their training. A total of 170 Fellows have completed their Rural Generalist training with QRGP. Over recent years, the program has been developed further to include additional pillars that enable research capability and, in conjunction with Royal Australasian College of Medical Administrators (RACMA), post fellowship leadership training to deliver a specially developed curriculum for the **Queensland Leadership for Clinicians** training program.

The maturity of Rural Generalist training in Queensland ideally positions the program, through strong stakeholder and partner contribution, to address current and future challenges and to

deliver solutions in the post fellowship space for all rural doctors, not just QRGP graduates; incorporating the NRG National developments.

1.2 Rationale for the Pilot Project

The NRG can contribute to a better-distributed rural medical workforce; more Rural Generalists ensures more sustainable workloads and improves retention [2]. But, for this to occur, rural doctors need to have an awareness of the NRG, a willingness to undertake the necessary training and be able to have access to the support required to navigate the pathway requirements.

Currently, there is a lack of data that provides specific suggestions from rural doctors about supporting, building and sustaining a rural medical career in the context of the soon-to-be-implemented NRG. This pilot study aimed to explore the factors, barriers, obstacles and challenges of rural general practice as described first-hand by the doctors who provide this service and to identify potential solutions to better support medical workforce; and in doing so, build and ensure a viable rural medical practice.

To investigate the unique support needs of rural doctors who have achieved Fellowship, Queensland Country Practice (QCP) and Health Workforce Queensland (HWQ) worked in partnership to pool their collective expert knowledge of rural and remote medicine and define a set of **Guiding Principles** that could inform the development of a Post Fellowship Support Framework. Doctors working in rural and remote locations across Queensland were invited to comment on how important each principle was and to identify any other principles necessary to support rural doctors who have achieved Fellowship working in rural Queensland.

Queensland has a distributed rural healthcare environment which requires integrated primary care and secondary care sectors to deliver the services that rural and remote communities need and expect. Service providers recognise this integration opportunity and have a history of success in delivering localised innovations and workforce and/or service initiatives that make a difference. Queensland's ability to innovatively solve local problems by growing local solutions is evidenced by the QRGP [3].

One learning from the QRGP experience has been that the capacity to support trainees can influence training uptake and successful completion. Understanding and providing the support requirements of doctors wishing to complete the training necessary to meet the Rural Generalist definition outlined in the Collingrove Agreement is critical to achieving the NRG objectives. A support framework that promotes the factors that enable doctors who have achieved Fellowship to practice in a manner consistent with the Collingrove Agreement definition of Rural Generalist and, at the same time, mitigates the inhibitory factors, may optimise uptake of the NRG and contribute to the realisation of a dynamic, highly skilled and sustainable rural medical workforce that can provide the healthcare needs of rural and remote communities.

It is intended that the learnings from this pilot project will inform the design, development and implementation of a Post Fellowship Support Framework that will be applicable to both current and future public and private medical practitioners. A Post Fellowship Support Framework will streamline access to structured support mechanisms, encourage uptake of post fellowship education opportunities and promote successful completion of the

requirements for endorsement under the NRG. This in turn will lead to a workforce with more Rural Generalists available to practice in rural and remote communities and a mechanism to design improved business models for the specialised services that Rural Generalists provide. Collectively, manageable workloads, optimised remuneration, increased job satisfaction and national recognition of rural generalism will advance the attraction and retention of doctors to rural areas, while making it easier to work across jurisdictions without loss of specialist recognition.

1.3 Objectives of the Jurisdictional Coordination Unit to support the National Rural Generalist Pathway

The objectives of the pilot project and expansion of Jurisdictional Coordination Units as outlined in the G02747 grant opportunity guidelines are to:

1. facilitate and lead an appropriate governance arrangement for the jurisdictional program;
2. manage the intersection between hospital-based training and primary care within their respective jurisdictions;
3. enable rural generalist trainees to meet the relevant GP College Fellowship endpoints by identifying appropriate training opportunities within the public hospital sector and working with primary care training partners to integrate placements;
4. provide case management of individual trainees as they navigate the pathway between training settings, including progression from pre-vocational to vocational training; and
5. provide and maintain support services to aspiring and existing rural generalists.

Whilst this project will align to all of the five above mentioned objectives, given the maturity of the QRG in Queensland, the focus of this pilot project will be Objective 5, **'provide and maintain support services to aspiring and existing Rural Generalists'**.

1.4 Scope

This report focuses on actions to support post graduate medical practitioners wishing to meet the Rural Generalist definition outlined in the Collingrove Agreement:

A Rural Generalist is a medical practitioner who is trained to meet the specific current and future health care needs of Australian Rural and Remote Communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team. (Collingrove Agreement 2018)

Only rural doctors working across Queensland in locations with a rurality category of Modified Monash Model four to seven (MMM 4 to MMM 7) were included in the pilot project.

Participants were invited to provide advice about their awareness of the NRG initiative and its potential impacts, their ability to practice in a manner consistent with the Rural Generalist

definition outlined in the Collingrove Agreement and what principles should underpin a Post Fellowship Support Model for doctors aiming to reach the NRGF endpoint.

Contributions were sought from doctors working in public and/or private sectors and those providing primary and/or secondary healthcare services. Doctors with a wide range of post graduate experience in rural practice participated.

1.5 Structure of the Pilot Project

Approach

The pilot project will be completed in **two phases**. During phase one, the building blocks for the Post Fellowship Support Framework were determined. This was achieved by obtaining and analysing experiential data from doctors working in rural and remote locations across Queensland. The data was collected either through interviews or an online survey. Phase one was completed during the latter half of 2020 concurrently as Jurisdictional Coordination Units were established. It was comprised of a semi-structured interview and online survey component. The findings of phase one are discussed in this report. During phase two, the building blocks from phase one will be used to construct the Post Fellowship Support Framework. The design and development of the framework will begin in 2021 as the functions of Jurisdictional Coordination Units are expanded beyond the establishment phase.

The Project Partners

Queensland Country Practice (QCP) is incorporated within the Queensland Rural Medical Service (QRMS), which is a Division of Darling Downs Health. QCP works with HHSs to support the sustainability of rural medical practice and promote excellence through integrated medical practices and training. QCP provides a range of client focused workforce and business services, including a comprehensive rural medical and health practitioner relieving service. Priority is given to address immediate workforce improvement opportunities.

Through a range of service and workforce design initiatives for Queensland Hospital and Health Services (HHSs), QCP's aim has been to improve healthcare access for rural communities by:

- improving the quality and range of medical services available in rural and remote communities;
- having doctors available where they are needed by assisting HHSs to redesign their workforce;
- having health practitioners available where they are needed through its relieving services;
- improving the efficiency and effectiveness of integrated primary and secondary rural medical service delivery;
- enabling primary care integration and delivery with expertise and support in areas of market failure;
- providing practical assistance and strategic advice to HHSs to enable doctors to provide services at full scope to meet the specific needs of their community.

Health Workforce Queensland (HWQ) is a rural workforce agency focused on ensuring regional, rural and remote communities have access to highly skilled primary healthcare professionals. HWQ has been delivering integrated health workforce solutions to Queensland communities since 1998 and has long-standing connections with the primary care workforce and health services in these communities. HWQ works alongside a multitude of stakeholders to deliver a range of sustainable primary care workforce solutions such as:

- an annual state-wide ‘all of health’ workforce needs assessment;
- maintenance of a database of primary care services and workforce;
- recruitment of permanent and locum GPs, nurses and allied health professionals including relocation support, retention incentives and tailored case management;
- delivery of a range of Continual Professional Development (CPD) accredited workshops specifically tailored to rural medical practitioners;
- scholarships and bursaries for rural and remote health practitioners to undertake further study and upskilling;
- rural immersion experiences for students to gain exposure to rural and remote practice;
- fellowship support to assist doctors working in rural and remote locations to achieve vocationally registration;
- expertise in research methodology including data collection, analysis and survey design.

HWQ’s in depth knowledge of the primary care workforce in regional, rural and remote Queensland, combined with expertise in data capture and analyses made them a well-suited partner with QCP in this Post Fellowship Support Framework pilot project.

The Project Team

The project team was led by the Project Sponsor, **Dr Dilip Dhupelia**, and comprised of members from both QCP and HWQ. Table 2 outlines the members of the project team.

Project Sponsor	
Dr Dilip Dhupelia – Director Medical and Clinical Services, Queensland Country Practice	
Project Team Members – QCP	Project Team Members – HWQ
Dr Ansmarie Van Erp – Director, Strategic Business Development	Ms Sarah Venn – Manager, Health Workforce and Service Planning
Dr James Collins – Medical Administration Registrar	Ms Meredith Sullivan – Team Leader, Health Workforce and Service Planning
Ms Chantal Stewart – Principal Advisor, Strategic Business Development	Mr Dean Selby – Health Workforce and Service Planning Officer
Ms Annette Butterworth – Principal Project Officer	Mr David Wellman – Data and Research Officer
Mr Davin Krause – Supporting Project Officer	

Table 2: Project team

1.6. Pilot Project – Guiding Principles

As previously mentioned, underpinning the efforts to develop a support framework for rural doctors who have achieved Fellowship, a number of interconnected guiding principles were developed. These guiding principles emerged from a series of discussions held by the project team. The development of the principles was an important exercise as they underpin the rationale of the pilot project and were used to guide the semi-structured interview questions and the Qualtrics © survey used in the qualitative and quantitative components of the pilot methodology respectively. These principles were introduced to the respondents via targeted questions to be validated and rated in terms of importance in developing a Post Fellowship Support Framework.

Principle 1: Collaboration and coordination between primary and secondary care is vital

The importance of acute and primary care sectors and operators working together cannot be over emphasised. Collaborative care across the continuum prevents avoidable diseases and improves the overall healthcare experience of patients and is the intended end point of NRGF.

Principle 2: Rurally based career paths are recognised and valued

Various factors motivate and/or influence a doctor to choose a rural career. A solid understanding of these factors is necessary in order to develop recruitment and retention strategies that encourage doctors to choose a career in rural or remote communities.

Principle 3: Job satisfaction is a critical element in working in rural and remote areas

The ability for an employer and a rural or remote community to accommodate the personal and professional skills and aspirations of a rural doctor and one which will promote job satisfaction will increase the likelihood of a doctor to be retained in rural medicine. As such, the principle of fostering job satisfaction must be built into any rural and remote support framework.

Principle 4: The ability to attain advanced skills is supported to meet community needs

Many doctors in rural and remote settings already practise across an extended scope. However, there is currently no national process for recognising and supporting advanced skills of existing practitioners, nor is there any nationally recognised pathway for training this workforce for the future. This principle is about policy development at a national level and the need to understand the barriers to and the support requirements of existing practitioners who aspire to meet the definition of the Collingrove Agreement; and the ability to successfully acquire the necessary additional advanced skills that are necessary to achieve this.

Principle 5: The ability to attain, maintain and upgrade procedural skills in hospitals or general practice is supported to meet community needs

As compared to their urban colleagues, rural doctors utilise more procedural skills as part of the comprehensive medical care provided to rural communities. Maintenance of procedural skills must be sufficient to ensure doctors remain safe and competent. Identifying procedural skills training and maintenance challenges can guide appropriate solutions for locally delivered training and should be considered when designing a support framework.

Principle 6: The ability to work across hospital and general practice facilities to provide coordinated care is supported

To meet the requirements of the Collingrove Agreement, doctors must deliver comprehensive general practice and emergency as well as other medical specialty care in hospitals (secondary care) and community (primary care) settings. A support framework to negotiate industrial and employment elements to enable this collaborative model of care is vital.

Principle 7: Education and training needs are supported

Rural doctors are expected to provide a comprehensive array of primary and secondary healthcare services. Being able to provide the services needed by a rural community requires ready access to appropriate training and education opportunities, both locally and nationally. An effective support framework with the capability of assisting doctors to source, complete and maintain the skills required to provide medical services that meet the needs of the community they service is vital.

Principle 8: Professional peer support is available

While rural medicine is often seen as rewarding and exciting, it can also be demanding and professionally isolating. An effective support framework will facilitate connecting rural doctors with the professional peer support they desire in order to flourish in their rural careers.

Principle 9: The viability of existing rural general practice is enhanced

Thriving General Practices are vital to meet the healthcare needs of rural and remote communities. Rural GPs are not only required to perform the role of care coordinators for their patients, they also need to work collaboratively with the public hospital workforce. The vital requirement in supporting general practices to remain viable is critical for providing best primary care to patients. An effective support framework will incorporate elements that are capable of minimising barriers and maximising enablers of general practice viability.

Principle 10: Clinical Leadership capability is recognised, enhanced, encouraged and supported

Effective leadership is pivotal for achieving a positive organisational culture. When organisations have skilled leaders, innovation, quality, and productivity tend to flourish, and a culture is created in which employees are more likely to feel motivated, empowered, and supported [4]. This in turn enables improved attraction and retention of a skilled workforce.

Positive organisational culture also promotes best practice care for patients while effective leadership in a clinical setting is associated with improved quality and safety [5]. Given the pivotal role effective leadership plays in achieving a positive organisational culture and the subsequent workforce and patient safety improvements, a support framework should incorporate clinical leadership as a primary focus. “When organisations prioritise the development of leadership, they build unity, create a growth culture, and align stakeholders to produce high-quality work.” [6]

2.0 Methodology

The pilot project sought to ascertain the support requirements of rural doctors who have achieved Fellowship and are undertaking, or planning to undertake, the steps necessary to meet the expected NRGp endpoint. To do this, the pilot project engaged doctors working in rural and remote communities across Queensland to obtain first-hand information about the type of support required.

A range of rural medical practitioners were invited to participate in the pilot project to maximise the likelihood of receiving contributions from a sample that was **reflective of the diversity** of doctors that exist in rural areas. These included Executive Directors of Medical Services, Rural Generalists engaged in public rural hospitals, rural GPs and a GP working solely in an Aboriginal Medical Service (AMS). Newly qualified, as well as experienced doctors, were invited to participate. Participation from such a wide range of doctors enabled the factors impacting rural medical workforce to be viewed from different employment and career experience perspectives across primary care, secondary care and AMS.

Participating doctors were asked specifically about their knowledge of and attitude towards the Collingrove Agreement Rural Generalist definition, and generally about the Australian Government Department of Health's NRGp policy. The doctors were also asked to either rate or weight the importance of the Guiding Principles that had been determined by the project team to validate whether these principles adequately captured the core requirements for building a Post Fellowship Support Framework.

The pilot project applied a mixed methods design using **qualitative** and **quantitative** data collection and analysis techniques.

The qualitative component

The qualitative component involved conducting in depth semi-structured interviews with current rural doctors. The one on one interviews were conducted using an interview guide (see Appendix 1). The interview questions were broadly grouped in order to:

- Investigate career history;
- Weight each of the proposed guiding principles for building a Post Fellowship Support Framework; and
- Discuss awareness and comments about the Collingrove definition and the NRGp.

Interviews were conducted as a peer to peer exercise by one of the two doctors from the QCP team. Interviews lasted 60 to 70 minutes and each interview was then transcribed as a verbatim record of the discussion that occurred.

Site selection for the project

A range of sites were selected for the project interviews. Each site represented a rural and remote township where medical practitioners live, work and practise. For the purpose of this pilot project, sites were deidentified and are referred to as ‘Town A’ or ‘Town B’.

Town A was a **single site** and Town B was a collection of **six sites**.

Town A represented what the project team identified as an “exemplar site” with demonstrated excellent clinical leadership, effective collaboration across primary and secondary healthcare settings and a high level of medical workforce retention and job satisfaction. In Town A, 100 percent of doctors worked across both primary, emergency and secondary care. The reason for selecting Town A was to identify the enabling factors that led to the success of integrated services in that town.

Town B was a virtual town comprising six sites matched for rurality to the exemplar site. Town B represented sites where clinical leadership, cross-care collaboration, staff stability and job satisfaction were demonstrated to varying degrees. In Town B sites, few doctors worked across both primary and secondary care and integrated models of care used to exist or are currently sub optimally existing. The purpose of selecting the Town B sites was to ascertain any inhibitory factors that exist in their towns. Town B sites were also deliberately selected to ensure representation from across Queensland (from north to south and from east to west) in order to better reflect the current or previous medical model in these towns, and the lessons learned, if any, from engagement models for doctors working in as wide a cross-section of rural Queensland as possible.

The selection of these sites (both Town A and Town B) was informed by the project team’s accumulative knowledge of and experience with the rural and remote health workforce and by analysing information gathered from a desktop audit. From these data sources, a community profile was developed for each site. For each site, the community profile indicated population size and demographics, geographic location, Socio-Economic Indexes for Areas (SEIFA) and included an inventory of current health workforce and services located in the town.

This information was evaluated against the **selection criteria** (see Table 3) to determine which sites should be included in the pilot project.

Selection Criteria for Town A

Town A was an actual town in a rural location in Queensland comprising of a single site that met the following selection criteria:

- *an MMM 4 to MMM 7 location*
- *the existence of at least one private general practice and a public hospital*
- *established clinical leadership*
- *existence of well-established connection, collaboration and good relationship between primary and secondary care*
- *a general practice with a history of involvement in training through mentoring medical students, junior doctors and GP registrars*
- *doctors working across both hospital and general practice settings*

Selection criteria for Town B sites

Town B comprised of six different rural and remote towns in Queensland that met the following selection criteria:

1. *A mixed sample of geographical location and remoteness including aspects such as:*
 - *a range of MMM 4 to MMM 7 locations*
 - *sites from 6 different HHSs*
 - *includes an AMS*
 - *reflect a mixed sample of the following employment models:*
 - *predominantly Senior Medical Officer (SMO) workforce model*
 - *Medical Superintendent / Medical Officer Private Practice (MS/MOPP) workforce model*
 - *the existence of at least one private general practice and a public hospital*
 - *GP Registrar workforce*
 - *Rural Generalist workforce (i.e. doctors whose practice meets the Queensland recognised discipline of Rural Generalist medicine)*
 - *Towns with heavy reliance on locums*
2. *A mixed sample of towns with differing relationships between secondary and primary care including those with:*
 - *a well-established connection*
 - *no connection*
 - *a historically good relationship that has now broken down or vice versa*

Table 3: Selection criteria for sites participating in the qualitative component of the pilot

Participants

A group of 32 doctors (17 male and 15 female) from Towns A and B were interviewed. In Town A, all currently engaged doctors were recruited to participate in the interview process. In Town B sites, three doctors (a private rural general practitioner, a rural generalist and either an Executive Director of Medical Services or a Director of Medical Services) from each of the six sites were recruited to participate in the interview process. An additional GP working solely in an AMS was also interviewed.

Approach

Semi-structured interviews were undertaken between August and October of 2020 and were conducted by the two doctors from the QCP team. Both doctors led the semi-structured interviews face to face (in Town A) and via either telephone or video conference using Microsoft Teams (for Town B sites). Each interview lasted between 60 and 70 minutes. The audio from each interview was recorded and transcribed verbatim. After the interview, the documented transcription was checked against the original recording to ensure accuracy of the record.

Interviews started by providing an introductory explanation of the interview process including information about the background and purpose of the project being undertaken. It was disclosed that the interviews would be audio-recorded and consent to do so and to participate was obtained. Confidentiality was discussed and it was explained that all responses would be de-identified when presented in this report.

Interviewees were invited to describe their rural employment experience including the number of years they have practiced in a rural and remote location and, for doctors with at least 10 years' rural experience, the changes to rural medicine practice that they have experienced during their rural career.

The focus of the interviews then moved to the guiding principles and interviewees were asked to rate each principle on a scale from zero to ten (where 0 = 'Not working at all' and 10 = 'Working extremely well') to indicate to what degree the principles are being successfully applied in their workplace currently. A series of prompting questions related to each principle were introduced to the discussion to elicit information about what the interviewee saw as the key enabling and inhibiting factors related to each principle.

The final part of the interview involved a facilitated discussion about the NRGP and the Collingrove definition. Questions were designed to explore how well these initiatives were understood by interviewees, to extrapolate how interviewees expect the initiatives will impact them and the communities they work in and to seek input into the design of a Post Fellowship Support Framework for all rural doctors.

The quantitative component

The quantitative component involved distributing a state-wide cross-sectional online Qualtrics © survey to postgraduate doctors engaged in General Practice, by HHSs and/or AMS. Participating doctors collectively represented the breadth of service delivery in these communities in geographically dispersed areas of Queensland.

Survey questions were broadly grouped into three categories focusing on:

- Demographics;
- The Collingrove Definition/NRGP; and
- The principles that should guide the development of a Post Fellowship Support Framework.

Questions related to demographics sought to ascertain current work arrangements, length of rural service and type of registration held by practicing rural doctors.

Questions related to the Collingrove Definition/NRGP sought to identify not only rural doctors already providing services that met the nationally recognised Rural Generalist definition outlined in the Collingrove Agreement, but also rural doctors with a propensity and willingness to do so. These questions also sought to investigate the enablers and barriers to practicing in a manner consistent with the Collingrove Definition.

Questions related to the Post Fellowship Support Framework sought to rate the principles by requesting respondents to score on a Likert five-point scale how important each Guiding Principle was.

The full list of survey questions has been included in the report appendices (see Appendix 2).

Site selection

Sites selected for the qualitative component of the pilot project (Town A and Town B sites) were **excluded** from participating in the quantitative component. Rural Doctors working in all other rural and remote sites from MMM 4 to MMM 7 locations across Queensland were able to participate.

Participants

A cohort of **626** rural GPs and rural hospital doctors were sent the email link to the anonymous online survey. This represented all doctors working in MMM 4 to MMM 7 locations across Queensland who had a known email address (i.e. an email address recorded in the HWQ database). The 32 doctors who had participated in interviews were excluded. The survey link was also sent to 135 practice/hospital managers in order to achieve wider distribution in MMM 4 to MMM 7 locations employing doctors with no known email address.

Responses were received from over **60** unique locations across Queensland.

A total of **156** doctors responded, reflecting a return rate of just over 25 percent.

These 156 responses were made up of replies from 96 male and 57 female respondents. Over 40 percent of respondents indicated they work across both general practice/AMS and hospital settings. The majority of respondents indicated they held specialist (General Practitioner) registration. (It should be noted that the survey results were self-reported by participating doctors and unintended misreporting may have occurred. For example, it was possible that a wrong option may have been selected in response to a closed-option question.)

Approach

The online survey was comprised of 28 questions, the majority of which were closed-option questions and a small number required a free text response. All returned survey responses were collated by HWQ in Statistical Package for the Social Sciences (SPSS) statistics software for storage and analysis.

The survey began by asking questions about the respondent's rural practice experience including number of years' service and the type of registration they held.

The next section of survey questions introduced the Collingrove Agreement and its definition of a Rural Generalist. In this section, questions sought to identify the type of setting they currently work in, explored which part(s) of the definition respondents met, enquired about whether respondents not already doing so were interested in working across both general practice and hospital settings and invited respondents to describe what supports or impairs their ability to work across both settings.

The final survey questions requested participants to rate on a five-point Likert-Style scale (where 1 = 'Not at all important' and 5 = 'Extremely important') how important each of the guiding principles are for doctors with Fellowship in General Practice working in rural and remote communities.

Data Analysis

The interviews and survey generated a rich dataset that consisted of **532** transcript pages.

Qualitative data was analysed thematically while quantitative data was downloaded to SPSS statistics software for analysis.

MS Word was used to manage and analyse the qualitative data and Qualtrics© was used to manage the quantitative data.

The first step in analysing the data involved data familiarisation. This process began during data collection and continued when listening to the recorded interviews and reading both the interview transcripts and survey responses. In framing the analysis to align with the pilot objective, emphasis was placed on exploring experiences founded on the Guiding Principles.

Thematic analysis is a multi-step process that begins with data collection and includes familiarising the data, generating codes, constructing themes, then reviewing, finalising and naming themes. Thematic analysis was applied to the interview transcripts to identify significant patterns and themes. The thematic analysis followed the approach outlined by Terry et al. (2017), an iterative process that involves going back and forth between the various phases of analysis [10].

The analysis phase involved robust discussion with members of the project team over a number of sessions. Crosschecking the qualitative and quantitative survey findings provided valuable opportunities to assist the team to identify key issues. These discussion and feedback sessions played an important part in the thematic analysis both in terms of “validating” and “making sense of” the data.

After thoroughly analysing the data, the early findings were initially presented to the managers of QCP and HWQ.

Following this, the findings were presented to the Town A and Town B pilot project participants at a key contributors’ forum in November 2020. This step provided an opportunity for the pilot project participants to validate the data.

Finally, the early findings from the pilot were then presented to key rural medicine stakeholders at a meeting in December 2020 (a list of invitees is provided in Appendix 3). Stakeholders attended face to face and virtually. This provided an opportunity for collective responses and comments from the stakeholders on the findings.

3.0 Results

From analysis of the combined qualitative and quantitative data, four main themes emerged. These themes were:

1. Connecting Primary and Secondary Care
2. Valuing a Rural Career
3. Supporting Training and Education
4. Valuing Rural General Practice.

Each theme can be mapped to one or more of the Guiding Principles. In addition to the four themes, multiple subthemes emerged, comprised of key factors that impact on and contribute to the associated theme.

Broadly speaking, the findings suggest that the development of a successful Post Fellowship Support Framework requires actions to be undertaken that are aligned to each of the four themes.

The principles were weighted by all respondents. The mean score for each Guiding Principle through the online survey respondents is provided in this section (3.1 to 3.4) under the theme to which it is relevant. The overall importance rating and further detail about the Guiding Principles – including ratings sorted according to sex, registration category and workplace setting of respondents as well as free-text comments related to the Principles has been provided in Appendix 4A and Appendix 4B respectively.

The results from the pilot project discussed in this chapter will be organised in terms of each of the above-mentioned emergent themes. In keeping with the project’s mixed methods approach, where possible the qualitative and quantitative findings are integrated, further supported with textual evidence and illustrated with italicised quotes and supported with medical literature references.

Table 4 provides an outline of the interplay between the themes and subthemes with associated framework guiding principles:

Theme 1: Connecting Primary and Secondary Care	
Guiding Principles	Subthemes
<p>Principle 1: <i>Collaboration and coordination between primary and secondary care is vital</i></p> <p>Principle 6: <i>The ability to work across hospital and general practice facilities to provide coordinated care is supported</i></p> <p>Principle 10: <i>Clinical leadership capability is recognised, enhanced, encouraged and supported</i></p>	<ul style="list-style-type: none"> ▪ Collaborative Models and Systems <ul style="list-style-type: none"> · System integrations and shared information · The public-private interface ▪ Trust, Leadership and Culture <ul style="list-style-type: none"> · Welcoming doctors to work across care settings · Making it easier for doctors to work across care settings · Streamlining the credentialing process · Employment strategies

Theme 2: Valuing a Rural Career	
Guiding Principles	Subthemes
<p>Principle 2: <i>Rurally based career paths are valued</i></p> <p>Principle 3: <i>Job satisfaction is a critical element in working in rural and remote areas</i></p>	<ul style="list-style-type: none"> ▪ Personal Factors <ul style="list-style-type: none"> · Lifestyle and community · Family considerations ▪ Professional Factors <ul style="list-style-type: none"> · Rural practice experience · Practice variety · Work conditions · Collegial support
Theme 3: Supporting Training and Education in a Rural Area	
Guiding Principles	Subthemes
<p>Principle 4: <i>The ability to attain advanced skills is supported to meet community needs</i></p> <p>Principle 5: <i>The ability to attain, maintain and upgrade procedural skills is supported to meet community needs</i></p> <p>Principle 7: <i>Education and training needs are supported</i></p> <p>Principle 8: <i>Professional peer support is respected, valued and available</i></p>	<ul style="list-style-type: none"> ▪ Training challenges unique to rural medicine <ul style="list-style-type: none"> · Cost · Training option flexibility · Management support ▪ Building capacity for rural doctor training <ul style="list-style-type: none"> · Locally available training · Mentoring · Coordination Unit function
Theme 4: Valuing Rural General Practice	
Guiding Principles	Subthemes
<p>Principle 9: <i>The viability of existing rural general practice is enhanced</i></p>	<ul style="list-style-type: none"> ▪ Rural GP in Practice <ul style="list-style-type: none"> · Recognition and reward · Attraction and workforce supply ▪ General Practice Viability <ul style="list-style-type: none"> · Funding model · Business support

Table 4: Themes and subthemes of findings

The four themes are individually discussed in the following sections of the report 3.1 to 3.4).

3.1 Connecting Primary and Secondary Care (Theme 1)

Introduction

This section introduces the results yielded from the components of the online survey and the semi-structured interviews pertinent to Guiding Principles 1, 6 and 10.

This section also introduces the findings from questions used in the pilot project's mixed method approach engineered to garner information about how well current rural doctors are informed about the Rural Generalist definition outlined in the Collingrove Agreement and how able they are to practice in a way that meets that definition.

An overview of the relevant data collection sources is summarised in Table 5.

From the analysis of these findings, the primary theme '**Connecting Primary and Secondary Care**' emerged.

This comprised of two subthemes:

- Collaborative models; and
- Trust, leadership and culture.

The theme, subthemes and contributing factors have been summarised in Table 6.

The Collingrove Definition articulates how a Rural Generalist bridges the siloes of primary and secondary care. The NRGF can therefore be a conduit for meeting the growing demand for people living in rural and remote communities to receive the comprehensive general practice, emergency care, and required components of other medical specialty care in hospital and community settings as part of a rural health care team, in a way that is coordinated, sustainable and cost effective.

Health is a shared responsibility between the Commonwealth and the states, territories and local governments of Australia, with each party holding defined responsibilities for healthcare funding, policy development and service delivery [7]. Like in other jurisdictions, Queensland has a blended healthcare funding model. Primary care is funded by the Commonwealth Government and traditionally is provided in private general practices. Secondary care is funded by the State Government and provided by public hospitals. This divided funding model has been conducive to primary and secondary service providers taking a siloed approach and cost or funding barriers being encountered when addressing challenges associated with meeting the needs of rural communities and introduces constraints to connecting care.

Delivering integrated care to patients requires coordination and collaboration across workforce and organisational entities and a shared accountability between health care teams [7]. Working at the primary-secondary interface, rural doctors play an essential role in achieving coordinated patient-centred care across the care continuum; an outcome that can only be optimised when primary and secondary care is connected at the service, workforce and funding design level.

Findings aimed at elucidating the prevalence of practice that meets the Collingrove Agreement definition of Rural Generalist amongst current rural doctors are discussed in this section. Also reported in this section are the findings from questions aimed at understanding whether doctors not working in a manner consistent with the Collingrove Definition might be willing to do so, and what the barriers are that prevented doctors from doing so. Understanding who might be interested in reaching the Rural Generalist endpoint and what is currently preventing them from doing so would provide invaluable insight into the design and development of a Post Fellowship Support Framework that can best meet the support needs of the rural doctor workforce.

Connecting primary and secondary care is important because without this, it is difficult for a rural doctor to provide coordinated care to patients across the care continuum and it is more difficult to practice in a manner that is consistent with the Collingrove Agreement definition of Rural Generalist.

According to Morley and Cashell (2017) quality healthcare requires a 'collaborative approach that involves shared decision-making, coordination and cooperation between the members of the health care teams, including medical practitioners' [17].

Data from the pilot project demonstrated that care connectiveness exists to varying degrees in different rural Queensland locations and that leadership, workforce models and funding sources can impact success.

Collaboration and Coordination between Primary and Secondary care (Principle 1)

1. If you had to rate the collaboration and coordination between primary and secondary care in your town on a scale of 0-10, with 0 not working at all and 10 working extremely well, how would you rate it?
 - a. Why did you give it that rating? Can you please give me a recent example?
 - b. Would you describe what is currently working well?
 - c. Would you also describe how collaboration could be improved?
 - d. How could you see that happening?
2. Please rate between 0-10 (with 0 not supporting at all and 10 supporting extremely well) how well you believe support systems work to foster collaboration and coordination of care in your town
 - a. In your opinion, what works well?
 - b. What can be done better or differently?

Ability to work across Hospital and General Practice facilities to provide coordinated care is supported (Principle 6)

1. Please rate between 0-10 the current situation in your town relating to ease of access for doctors to work in both primary and secondary care settings?
 - a. Why did you give it that rating? (probe for specific examples)
2. I would now like to ask you about your experience about working in both General Practice and hospital settings?
3. Are you interested in working across both primary and secondary care?

Clinical leadership capability is recognised, enhanced, encouraged and supported (Principle 10)

1. As a rural doctor, why is it important that you have good clinical leadership in your town?
 - a. What are some examples of good leadership in your town and what could be improved?
2. Can you me about tell about your interest in developing your own leadership skills?
 - a. How could you be supported to do that? If not/why not?
3. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, what would you see is its role in providing opportunities for leadership development and training?

National Rural Generalist Pathway (NRGP)

The Commonwealth Government is currently moving ahead in developing a National Rural Generalist Pathway.

1. Are you aware of this policy?
2. Do you think this will impact in any way on your career pathway?

Collingrove Agreement

Both colleges have currently been tasked to work with the AMC and the Medical Board to obtain recognition of Rural Generalism as an endorsement following fellowship in general practice. The Commonwealth has currently accepted the Collingrove Agreement as the definition of Rural Generalism. The definition states:

"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team."

1. Should Rural Generalism become recognised in such a way by the Medical Board:
 - a. How would this impact you?
 - b. Would you be encouraged to undertake further training to meet this definition of Rural Generalist? If so, what? If not, why?
2. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, what would you see is its role in supporting rural doctors who have achieved Fellowship to obtain whatever is necessary to meet this definition?
3. In your opinion, other than what we discussed, what else can be done to support post fellowship doctors in obtaining whatever is necessary to meet this definition?
4. Is there anything else that you wish to add?

Online survey questions related to:

1. The Guiding Principles: Questions 15, 20 and 24
2. Collingrove Agreement: Questions 7 to 14
3. NRGPs: Questions 26 to 27

Table 5: Data collection sources: interview guide and principles related to a connected primary and secondary service

Given the complex environment of rural healthcare in Queensland and the intimate way that connectedness across sectors impacts the practice of rural doctors, it was not surprising that the first theme to emerge from the thematic analysis was ‘connecting primary and secondary care’.

Theme 1: Connecting Primary and Secondary Care	
Guiding Principles	
Principle 1	<i>Collaboration and coordination between primary and secondary care is vital</i>
Principle 6	<i>The ability to work across hospital and general practice facilities to provide coordinated care is supported</i>
Principle 10	<i>Clinical leadership capability is recognised, enhanced, encouraged and supported</i>
Subthemes	Contributors
<ul style="list-style-type: none"> ▪ Collaborative Models and Systems 	<ul style="list-style-type: none"> · System integrations and shared information · The public-private interface
<ul style="list-style-type: none"> ▪ Trust, Leadership and Culture 	<ul style="list-style-type: none"> · Welcoming doctors to work across primary and secondary care settings · Making it easier for doctors to work across primary and secondary care settings · Streamlining the credentialing process · Employment strategies <ul style="list-style-type: none"> - Engagement models - Workplace and rostering flexibility

Table 6: Themes 1 with subthemes and contributors

Results

Quantitative Findings

Guiding Principles

Online survey respondents were asked to rate how important each Guiding Principle is for the design and development of a Post Fellowship Support Framework on a scale from one to five (1 = Not at all important; 5 = Extremely important). The results relevant to the theme of Connecting Primary and Secondary Care are provided as follows.

	Guiding Principle	Mean Rating (out of 5)
•	Principle 1 <i>Collaboration and coordination between primary and secondary care is vital</i>	4.52
•	Principle 6 <i>The ability to work across hospital and general practice facilities to provide coordinated care is supported</i>	4.06
•	Principle 10 <i>Clinical leadership capability is recognised, enhanced, encouraged and supported</i>	4.17

The mean rating for each of the principles was greater than four (4 = Very important) indicating that survey respondents believed it was necessary to incorporate these principles into the design and development of a Post Fellowship Support Framework.

Collingrove definition

The survey provided an opportunity for rural doctors to provide their feedback about the Collingrove Definition and NRGF and how a Post Fellowship Support Framework could assist doctors to achieve the defined Rural Generalist endpoint. The pilot project team was particularly interested in whether rural doctors would be interested in working across both general practice and hospital services.

To explore this, respondents were first asked to choose which option listed best described their current work setting. Respondents were next asked to indicate ‘Yes’, ‘No’ or ‘Unsure’ to the question “In the last 12 months have you worked in a manner consistent with the Collingrove Agreement?” The results are presented in Figure 2 (for a breakdown of the responses sorted by work setting, see Table 7).

Work setting	Have you worked in a manner consistent with Collingrove Agreement in the last 12 months?			
	Yes	No	Unsure	Total
General practice only	12	26	15	53
Hospital only	17	7	2	26
AMS only	3	4	1	8
Both general practice / AMS & hospital	57	2	4	63
Total	89	39	22	150

Table 7: Responses to "Have you worked in manner consistent with the Collingrove Agreement in the last 12 months? by work setting

The results indicated that **59.6%** of respondents had worked in a manner consistent with the Collingrove Agreement in the previous 12 months (response = Yes).

Interestingly, within this cohort, **12** respondents also indicated they work in a general practice setting only and **17** respondents indicated they work in a hospital setting only.

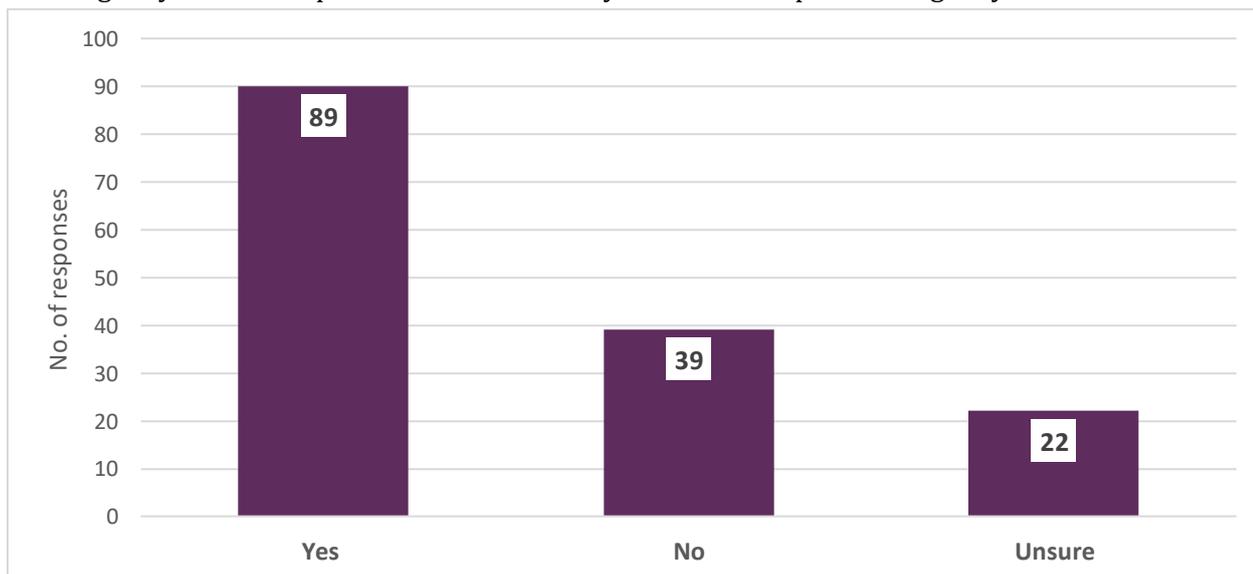


Figure 2: Work was consistent with Collingrove Agreement in the previous 12 months

Of the remaining respondents, **39** doctors indicated that they had not worked in a way consistent with the new agreement (response = No) and a further **22** indicated that they were unsure (response = Unsure).

Respondents who had indicated a 'No' or an 'Unsure' response were asked to outline which parts of the Collingrove Agreement they had not met. The responses provided included not having worked in either a hospital or general practice setting and not having completed advanced skill.

Respondents who indicated having worked only in a general practice or AMS setting were subsequently asked if they had interest in also working in a hospital setting. Of these respondents, **64** percent showed some level of interest in also working in a hospital setting. Some respondents even indicated that they had advanced skills that they would be willing to use in the hospital setting. A variety of comments were offered by respondents about what had prevented them from pursuing their interest in working in a hospital setting. Commonly reported reasons included uncertainty about how to go about working in the hospital setting and what, if any, support might be available for them to work across both settings.

Respondents who indicated they would not be interested in working in the hospital setting (36 percent) were also asked to provide comments to explain the 'No' response.

Precluding reasons that were provided by respondents tended to report a lack of capacity to take on more work, a sense of feeling unwelcome at the local hospital, concern about how taking on hospital work would impact their general practice work and a need to be upskilled in emergency work.

The results, including summarised reasons and free text responses for nominating a 'No' response, are provided in Table 8. A summary of all free text responses related to working across primary and secondary services provided by respondents working only in a general practice / AMS are available in Appendix 5.

"I'm currently balancing parenthood with work and would find it difficult to manage on-call at the hospital with private GP Work and childcare." (GP_S_p550).

In like manner, respondents who indicated having worked only in a hospital were asked to indicate their interest in also working in general practice.

This cohort indicated less interest in working across both primary and secondary settings than the previous cohort. Only **19.2** percent of doctors working only in a hospital setting indicated that they were interested in working in a general practice setting as opposed to **29.5** percent of GPs indicated that they were interested in working in their local hospital. Within the cohort of doctors who currently work only in the hospital, **38.5** percent indicated a 'Maybe' response to the question of whether they were interested in also working in general practice. The main reasons reported for not indicating a 'Yes' response was related to salary and employment conditions.

Interest in working in hospital	n	%
Yes	18	29.5
Maybe	21	34.4
No	22	36.1
Total	61	100.0
Reason for 'No' response		
<ul style="list-style-type: none"> • no capacity due existing heavy general practice workload • paperwork/credentialing burden associated with working in the hospital setting • concerns that working in both settings would include after-hours work, cause fatigue and impact ability to see general practice patients the following day • general practice more conducive to work / life balance because it offers part time work that fits around personal commitments • would need emergency upskilling to feel comfortable working in a more acute setting. • feeling out of one's depth returning to emergency • don't feel welcome to work at the hospital; unwelcoming culture towards GPs in some hospital locations; work would need to be done to improve the collegiality between local general practice and hospital in some rural locations. • concerns that a GP would be paid as a junior doctor while undertaking any required skills training. • a lack of confidence that work rosters would offer the level of flexibility needed to successfully work across primary and secondary care • the volume of paperwork required to work in the rural facility (such as credentialing) was indicated by a few as a perceived barrier and some even indicated it had stopped them from proceeding in working closer with the hospital • nearing retirement. 		

Table 8: General Practice / AMS-based doctors' interest in working in a hospital

Hospital based doctors who indicated they would not be interested in working in the general practice (response = No) provided a range of reasons for this.

As with the GP cohort, precluding reasons included a lack of capacity to take on more work. Other reasons included a sense that working reduced hours in general practice may not be conducive to providing quality patient care and the realisation that pay and employment conditions were less favourable in general practice. The results, including reasons hospital-based doctors provided who indicating a 'No' response to also working in general practice, are provided in Table 9. A summary of all free text responses related to working across primary and secondary services provided by respondents working only in a hospital is available in Appendix 6.

Finally, respondents who indicated having worked across both a general practice / AMS setting and a hospital setting were asked to comment on what enabled this to occur and what else could be done to foster collaboration between the two settings.

The comments provided can be summarised into three main areas – **flexibility** and rostering, **sharing of patient information** and a **single employer** model across both sectors. Free text responses related to working across primary and secondary services provided by respondents working across both settings are available in Appendix 7.

Interest in working in general practice	n	%
Yes	5	19.2
Maybe	10	38.5
No	11	42.3
Total	26	100.0

Reason for 'No' response

- no capacity due existing heavy workload leaving no time for general practice
- lower remuneration and employment conditions
- leave entitlements (e.g. professional development and paternity) not available in the general practice setting
- high professional costs in general practice;
- concern that working a small amount of time in general practice would impede ability to able to provide a quality service to patients especially in terms of the timely follow-up patients need
- if financial incentives and rostering practices were flexible enough to support work in both settings, there might be interest
- unable to source backfill/locum cover.

Table 9: Hospital-based doctor interest in also working in general practice

In summary, the survey responses found that GPs had a higher level of interest in also working in a hospital setting than hospital-based doctors had in also working in a general practice setting but that overall, there was an encouraging amount of interest in working across care settings from both doctor groups. The key contributing factors common across both doctor groups were existing workload, remuneration and employment conditions and inflexible rostering practices. Doctors who were already working across both settings indicated that rostering, information sharing, and employment models were the main factors that foster cooperation and collaboration between primary and secondary healthcare services.

Qualitative Findings

Collaborative models and systems

Each interview started with questions about a practitioner's experience regarding the collaboration between primary and secondary care in the (rural or remote) town where they work. Collaborative models and systems included workforce, business and clinical systems that were available to and/or shared across the primary and secondary sectors. There appeared to be strong consensus regarding the importance of system integration between the general practice and the local hospital. During interviews, two key contributing factors were consistently raised.

System Integrations and Shared Information

Many clinicians reported to be extremely frustrated about the lack of integrated information technology systems, citing the poor information technology functionality and suboptimal infrastructure as significant points of frustration. This is illustrated by following comments:

"Fix the IT systems, they're atrocious, there is a real lack of insight into how critical the IT systems are for quality improvement. If you don't understand that relationship, you're digging holes for yourself" (EDMS_D21).

"I need two passwords, then, jump through seven, eight, nine clicks, waiting to get into the system It's hard with that extra barrier, a bit isolating out here when you can't get the information you need." (PHO_D4).

"Wi-Fi access is a real issue as is accessing records, I think the system for GPs to access hospital [information] is too clunky and hard." (GP_C26).

The existing systems of each primary and secondary service maintaining their own patient record was also often reported to be a missed opportunity for improving the patient experience by coordinating care across the continuum. Particular reference was made to challenges arising when patients who have recently received emergency or inpatient care present to their GP for follow-up sooner than their discharge summary can be delivered.

"It is somewhat insulting, that providing good quality primary care cannot be done aligned with a rural hospital emergency department. It might be more recognised if there is alignment with IT resources for patients presenting after hours when no General Practices provide this cover". (S_p549).

When asked how collaboration and coordination could be improved, there was strong support for sharing patient information across hospitals and primary care with a single, joined-up medical record. It was proposed that enabling general practice and hospital doctors to utilise a **common patient health record** would provide rural doctors with immediate access to shared information, remove delays in delivering discharge information to local doctors and improve continuity of care for patients.

It was noted that some communities have managed to make significant progress towards shared records with some towns reporting the use of shared records across hospital and general practice settings.

"I can get directly on to the hospital system ... my health record is good with the public hospital because I can look at [patient] bloods, pathology, discharge summary." (GP_C26).

The Public-Private Interface

Optimal delivery of primary and secondary healthcare services to communities where the healthcare is multi-funded by various private and government bodies requires an excellent interface between these entities [8] and achieving that often starts with understanding each other's business. Responses to the semi-structured interviews suggested that there is more work to be done to improve the public-private interface with both sides of healthcare asking for understanding of the profession and the perspectives of the other.

"There's been a bit of 'us and them' mentality between us [general practice], which we want to move on from that, we want to really build that relationship that we have with the hospital." (GP_B22).

The divergence of responsibility for primary and secondary care across general practice and hospital settings respectively has led to a disparate relationship between health service providers in some locations. A doctor described the relationship as one that was broken and needed rebuilding.

“Having come from a background as a procedural private GP, working as a VMO, they [Queensland Health] haven’t done themselves any favours in picking up that relationship, that ‘broken’ relationship, but I’ve started rebuilding.” (MD_P27).

Each interviewee understood the importance for primary and secondary healthcare services to collaboratively operate, plan and communicate. However, the data suggested that more needs to be done to prevent doctors from working in silos. This might require fostering a respectful understanding of each services’ expectations and priorities.

“QH needs to work out how to do a blended model, so private practitioners can come into their facilities and look after their own patients. The public/private divide is destructive. It should be private practice first, and the public appointment second. QH need to understand that good primary healthcare and good private practice is reducing the burden on the public system.” (DMS_B14).

Trust, Leadership and Culture

The second sub theme related to the role of *Trust, Leadership and Culture* in facilitating collaboration and coordination between primary and secondary care. Many doctors commented on the importance of effective clinical leadership to create supportive environments, flexible employment arrangements and the ability to practice to one’s full clinical scope. Respondents often commented that good leadership was underpinned by a positive culture and a sense of trust.

Access to inspirational medical leaders, who not only offer collegial support but also a trusted relationship, is highly valued by rural doctors.

“I think it is that collegial support... somebody that you can trust, and that you can raise concerns with, and that you can discuss patients with.” (GP_VMO_N11).

Leadership and a trusting culture were reported to be fundamental for achieving positive workplace environments as this often also leads to connections between primary and secondary sectors. It was viewed as relevant for all settings; no matter *“how big or small your organisation is, the culture, starts at the top”*. Interviewees also reported that *“if you have a good culture of support and friendship, I think those are the things that will draw people to work in the hospital”*. This suggested that leadership, trust and a positive workplace culture goes beyond connecting primary and secondary care; and also influences attraction and retention.

“Clinical leadership is vitally important to attract and retain people. If they don’t feel there’s good leadership, or feel they’re not supported, that’s reason they leave.” (DMS_C23).

Positive leadership and a trusting culture were also identified as causative factors for positive outcomes during periods of change or uncertainty; as well as for ensuring a workforce that is content. Both of these outcomes were reported to facilitate staff retention.

“[Drs X and Y] been incredibly enthusiastic, which is quite inspiring, and if they weren’t driving that [change] hard, I don’t know whether the same outcome would have happened.” (GP_VMO_G7).

“Important to have good clinical leadership in our town because it makes you feel supported. If you don’t have good clinical leadership, you don’t have happy doctors. And if you don’t work with happy doctors your juniors don’t want to come back.” (RMO_S13).

Analysis of responses from interviewees related to leadership, trust and culture, highlighted key contributing factors critical for connecting primary and secondary care. These are discussed next.

Welcoming doctors to work across both primary and secondary care settings

Responses provided during the interviews indicated that an 'us and them' mentality prevails in some rural locations and that positive leadership is needed to improve this barrier to working across primary and secondary care settings. One reason reported for this sentiment was that doctors are under increasing pressure to manage busier and more complex caseloads. In an effort to prioritise services provided, it was common for hospital doctors to deprioritise less acute healthcare needs. When this was not managed with primary care providers in a coordinated or respectful way, it was possible for hospital doctors to give the impression that primary healthcare was less valuable than the provision of secondary and emergency healthcare.

"A large confounding factor in that is the way the hospital is set up and there is again increasing pressure to hand Primary Health care back to Federal so to just have the hospitalist type approach." (SMO_C16).

Some GP respondents who had a propensity for working across primary and secondary care settings reported instances where on expressing their interest in working at the hospital the local hospital responded in a manner that was perceived to be unsupportive, dismissive or uncooperative. These experiences were described as fostering a sense of ill-will between general practice and hospital doctors with GPs feeling unwelcomed and that they were being unfairly denied the opportunity to work to their full scope.

"QH does not support or encourage GPs to work in their hospitals. I have admitting rights to [Hospital X] but over the 5 years that I have been here we have been increasingly discouraged from admitting and caring for private patients." (GP_S_p546).

It also resulted in some GPs believing that they are deliberately sidelined by the hospital in favour of their own doctors.

"I feel like sometimes the hospital staff want their own people. They don't necessarily want people who need to be educated or trained up." (GP_M33).

One doctor reported observations of a rural hospital being reluctant to engage a GP to provide secondary services saying that rather than encouraging private GPs to take on hospital-based work and provide rural generalist services, the hospital was inclined to advocate for hospital doctors to perform primary care. The doctor proposed that the implementation of the QRGF had contributed to this divide and had created a Rural Generalist medical workforce that behaved in a way that was contrary to the intent of the Rural Generalist role by discouraging private rural GPs to provide both comprehensive primary care and hospital-based secondary care services.

"I've seen very hostile approaches to the private GPs when they've offered their services to the Hospital, flatly refused, that is just completely contrary to the RG model, so it's about changing the culture on both sides." (SMO_C16).

For some doctors, the sense of GPs feeling unwelcomed in the hospital setting started many years ago. A doctor reflected that for decades GPs provided procedural services to the local hospitals such as obstetrics, anaesthetics and minor surgery but over the years this has been increasingly discouraged. The doctor described a period when the government announced wide-scale redundancies, during which some GPs were left feeling abandoned.

“GPs that had previously worked in and put in a lot of time and effort working in the hospitals now suddenly feeling like they’re outcasts, their skills not needed.” (MD_P27.)

In contrast, in some rural communities, the doctors described the hospital as being welcoming of GPs who also wanted to work in the hospital and vice versa. One GP who had recently arrived in a rural town and wanted to work across both settings reported about that hospital:

“If you come here and say, I want to be a GP, but I also want to be on-call and work in emergency and reduce fractures and look after inpatients, done! This is the place to be, yes. That’s easy.” (MS_M24).

The results showed that rural doctors working in one setting who also wanted to work in the other setting felt welcome to do so in varying degrees in different rural locations. The results also suggested that the degree to which a doctor feels welcome to also work across other healthcare settings is directly proportional to the likelihood that they will work across both primary and secondary care settings. Further, the findings demonstrate that positive leadership and a trusting culture is necessary to promote respect for the value of both primary and secondary healthcare services and to enable doctors with a desire to work across both settings to achieve this.

“Influence at system level to ensure that opportunities arise for GPs to be employed at the hospital and that there is “an open arms approach” to employment opportunities.” (SMO_C16).

Making it easier for doctors to work across both primary and secondary care settings

In an environment where a mix of public and private sector doctors provide primary and secondary care across the full spectrum of community, hospital, AMS and general practice settings, a key factor to support an integrated workforce is to make it easy for doctors to work across the facilities and sectors. Analysis of quantitative and qualitative responses related to Guiding Principle 2 validated this; however, respondents frequently reported that their lived experience was that it is often not easy to work across sectors.

It was suggested that the delineation of responsibility for primary and secondary care between the Commonwealth and State governments respectively perpetuated the problem and that removing this separation would make it easier for GPs to work in hospitals and for hospital employed doctors to work in general practices.

“Get rid of the separation of primary care and hospital-based care and deliver all care under a certain size in a hospital system with primary care rooms. The solution is one entity, all situated together with less competition and all on an equal footing.” (ED_F28).

Interestingly, when asked to comment on the ease of access for doctors to work both in general practice and in the hospital care settings, all doctors from Town A said that it was easy and even encouraged. These doctors also reported that clinical leadership capability was recognised,

enhanced, encouraged and supported in Town A.

“If you come to this town and want to work across both sites, that’s encouraged. You can work in private practice with VMO rights or work in a SMO role and work as much or as little as you want here as a contracted GP. There’s flexibility, certainly we’re very encouraged to work across both sites.” (SMO_C3).

Similarly, one Medical Superintendent explained,

“All doctors are working in both worlds... which I think is a very positively attractive part of our medical model, locally.” (GP_MS_M1).

The findings suggest that some doctors are willing to provide both primary and secondary healthcare services but may become discouraged if the process is too onerous. Rural doctors have reported that they need support to practice in a way that satisfies the Collingrove Agreement definition of Rural Generalist. Strong medical leadership is essential to manage barriers that inhibit the ease of which doctors can work across healthcare settings.

Streamlining the credentialing processes

A major barrier impacting ease of working across care settings reported by many GPs was the hospital credentialing process. Most doctors reported feeling pressure from relentless paperwork and described the inefficiencies this brings to their practice and hospital work. Some doctors labelled the process “cumbersome” or branded it “the red tape”. Doctors felt that credentialing should accommodate the ease with which GPs are able to gain employment in the hospital, but instead they viewed it as ‘very hard’.

“It is very hard to be a hospital procedural doctor in Qld and work in General Practice; Mandatory training and QH credentialing requirements are almost prohibitively demanding for one person with two roles.” (SMO_p557).

Others even viewed the credentialing process to be a deliberate deterrent. One doctor noted:

“There’s the usual intentional barriers for working at the hospital that has to do with credentialing.” (GP_VMO_M2).

However, the same GP acknowledged that although the burdensome credentialing process was an intentional barrier, the complexity of the process was influenced by the need to undertake robust checks in order to provide an assurance that doctors working extended scope of practice were appropriately qualified to do so.

“Obviously they’re there for reasons, it’s an understandable challenge, it’s necessary.” (GP_VMO_M2).

Inconsistent credentialing requirements across different HHSs was also seen to be problematic.

“It’s a bit strange that you can get approved for one, in a different health service and not in this service. Coordination between the credentialing committees is a problem.” (GP_MS_M1).

Employment Strategies

- Engagement Models

The findings demonstrated that most rural doctors who currently work across only one sector had some propensity to work across both healthcare sectors. When **61** doctors working exclusively in general practice or AMS settings were asked whether they would also be interested in working in the hospital **18** respondents (29.5 percent) selected 'Yes' and **21** respondents (34.4 percent) selected 'Maybe'. This indicated that almost two-thirds of the doctors not currently working in hospital settings could be interested in an employment opportunity in a hospital setting if conditions were favourable.

"I'd like it where I would maybe work half the week in one place, half in the other place, like a combined thing." (GP_M33).

Respondents described a variety of employment models that would allow doctors to work across both primary and secondary care. It was generally agreed that no single model would be appropriate for every situation, but it was also noted that most of the models could be categorised as either being a **fractionated model** or a **single-employer model**.

"Work life balance is taking an increasingly important role for developing workforce. Fractional appointments and doctor specific interest needs being met seem high on all our staffs' priority lists." (GP_S_p559).

Respondents described lived experiences of being offered an engagement opportunity that did not work for them:

"They wanted to stay with the MO/MSPP model, which is totally inappropriate for the town of this size." GP_S29.

and also commented that the lack of variability in engagement models offered was a deterrent to taking a fractionated appointment. One respondent remarked:

"I support a centralised process but firmly believe needs differ, so regional variability needs to be taken into account." (S_p568).

Others discussed how they changed models into successful collaborative practice models where doctors work both in a general practice clinic and at the hospital.

"We came up with a solution which was SMO with right to private practice, and we kept the medical officer with right to private practice, because that's the position used for registrars. It's been going for a few years and it works, way better than what we were doing before." (GP_MS_M1).

"A single employer model works well to allow for recruitment of sufficient doctors to meet primary care needs during hours and on call after hours." (Hospital Employed Doctor_S_p552).

Respondents from Town A reported a high-level of satisfaction regarding employment models that made working across primary and secondary care succeed. Both a Visiting Medical Officer (VMO) and Senior Medical Officer (SMO) remarked that flexibility is the key to success, noting that a workplace that demonstrated the necessary flexibility to change employment models to make them work for the doctors is an attractive incentive to recruit and retain doctors.

“Every individual now works out their own fractional appointment with the hospital, or as a VMO if that’s the preference. It works well because there’s so much flexibility.” (GP_VMO_M2).

Whilst fractionated appointments and single-employer models can both succeed or fail, the critical success factor is strong medical leadership. Leadership promotes a ‘can-do’ attitude that is responsive to the needs of the doctor whilst maintaining the ability to meet the healthcare needs of the rural community. Fearless leadership embraces flexible employment models that are designed after giving equal consideration to the needs of the doctor and the employer. Positive leadership also facilitates making adjustments to individual employment models when the needs of the doctor or the employer change.

- Workplace and Rostering Flexibility

The most common response to the question ‘what would ease access to work across settings?’ was ‘workplace flexibility’ and ‘rostering’ particularly as it relates to ‘fatigue management’, and ‘access to professional development’(PD).

“Having flexible rostering/contracts allow me to work at both locations and avoid fatigue/on call when I am at the general practice plus, I have access to PD.” (SMO_S_p551).

Balancing the competing interests of a doctor working across primary and secondary settings was reported to be difficult, particularly in the context of fatigue because it’s not uncommon for GPs also working as hospital doctors to work several hours straight to avoid “abandoning” their patients.

“If you’re up all night [at the hospital], you either make the decision to cancel your patients [at the practice], or you just work, which is usually what happens.” (PHO_H6).

It was reported that working across two sites when you are a GP poses unique care challenges if your hospital work impairs your ability to be in the general practice every day.

“I find it difficult, the general practice side, if you want to follow up patients at a certain time but may not have days available because you’re at the hospital those days.” (GP_SMO_C9).

Respondents also commented that workplace and roster flexibility was vital for GPs who also work across the hospital setting to ensure working across both sites remains financially viable.

“Lack of support to balance the work between the hospital and GP work is killing us. Running a Practice to support the hospital is a headache. Financially it is not viable and adds to never ending management role which is poorly supported.” (GP_S_p557).

Discussion

These findings confirm that doctors have a propensity and desire to work across primary and secondary care but to achieve this, they require support to ensure working across both settings remains viable and patient care is not compromised. The primary barrier to working across both settings was reported to be a lack of flexibility in the workplace and in rostering practices. If these challenges are to be overcome, it will require strong leadership and a commitment to providing the support needed by doctors to deliver safe practice in a financially viable way.

The survey findings also showed that many doctors attracted to working across both primary and secondary care were discouraged by a perceived lack of welcome or high level of difficulty to do so. A divide between primary and secondary care providers and a perspective that each party was a stand-alone entity solely responsible for the provision of either primary or secondary care was seen to contribute to a lack of welcome to work across sectors. The burdensome paperwork and bureaucracy involved in the credentialing process, a reluctance to customise employment models and rigid rostering practices were reported to contribute to the ease at which doctors could work across care settings.

Strategically, it is important to ensure doctors wanting to work across primary and secondary care are welcomed and supported to do so.

It is also suggested that strategies are implemented to reduce the paperwork and bureaucracy involved in the credentialing process. Streamlining the credentialing process by removing duplicated steps and eliminating the need to provide the same information more than once is seen as long overdue. A statewide credentialing system is achievable and needs to be actively pursued.

Employers should be encouraged to adapt fractionated or single-employer employment models to match the needs of the doctor and the service provider. Workplaces should also be supported to respond to requests for flexible rostering. These practices were reported to promote manageable workloads and minimise financial disadvantage, thereby affording doctors a greater opportunity to undertake work across care settings.

Analysis of the findings related to the theme 'Connecting Primary and Secondary Care' were categorised into two subthemes, each of which identified contributory elements.

The first subtheme, *collaborative models and systems*, described how more was needed to be done to facilitate integrated systems and shared patient records in order to support connected care. It also showed that opportunities to improve the public-private interface must be actively pursued to improve the connectiveness of primary and secondary care.

The findings revealed that ICT and its infrastructure was a cause of frustration for rural doctors. They described incompatibility of systems between the hospital and general practice settings, poor system performance and restrictions on access to shared patient records as factors that inhibit the ease and degree of collaboration between primary and secondary care providers. The timeliness of post discharge summaries was of particular concern to GPs. Rural doctors suggested that collaborative sharing of information through integrated ICT systems would improve patient safety by ensuring the right information was provided to the right person at the right time and also improve the overall health experience for patients by reducing the requirement to repeat information or retell stories.

There are already examples across the state where there is a 'joined up' single medical record in small rural towns. This means Doctors can view the patients' records whether the patients turn up at the ED, need acute admission into hospital, see GPs at the primary clinic or are residents of aged care facilities or of multipurpose health services. A "joined up" single medical record is the gold standard we need to pursue, to ensure a quality service is provided safely to the patient and also ensuring practitioner satisfaction that the full history and current pathology and

diagnostic test results are available at all times to enable them to make the correct medical decisions for the patient.

All of these efforts require strong medical leadership that exercises courage and promotes a positive culture of trust. Because of this, opportunities to recognise, enhance, encourage and support clinical leadership should also be pursued. The second subtheme, *'trust, leadership and culture'*, highlighted the integral need for strong medical leadership to establish a culture of trust and the role this played in achieving connected care.

It discussed how creating a welcoming attitude improved the ability of doctors to work across care settings. It also discussed how strong medical leadership promotes strategies that make it easier for doctors to work across both sectors and positively influence administrative processes, employment models and flexible rostering.

Progressing the development of Leadership capability in Queensland

It is appropriate at this stage to reflect on the steps that Queensland is undertaking to foster leadership amongst our Rural Generalists once they have achieved their Fellowship.

After 10 years of rolling out the QRGP, it became apparent that Clinical Leadership could be better prepared and supported in many areas of rural Queensland. There were various reasons for this including areas having a small (and therefore very busy) workforce, a declining workforce, and even absence of an established workforce leading to locum dependency. The development of leadership skills and management skills is not, therefore, high priority in such areas.

As more and more Queensland Rural Generalist Trainees achieved Fellowship, there was a realisation that these well rounded and well-trained doctors, providing a skilled workforce in rural areas, often found themselves in leadership roles by default or by community expectation. The question that needed to be asked was did they have sufficient learnings and adequate preparation to undertake a leadership role?

Whilst Queensland Health does provide an opportunity for doctors doing vocational training to have exposure to leadership programs such as the "Step Up" program run by the Clinical Excellence Queensland, many trainees simply do not have the time to undertake these, having to balance their high workloads with their ongoing studies towards Fellowship.

At a forum held in Roma in 2015, a strategic discussion was held as to the ongoing priorities for the well-established Queensland Rural Generalist Program. Not surprisingly, leadership training and development was identified as a priority. This was because there was a recognition that in the towns where the Rural Generalist workforce was thriving and easy to recruit to, this was attributable to the existence of good and supportive clinical leadership.

The outcome was the development of the **Leadership for Clinicians Program** for the QRGP in conjunction with the Royal Australasian College of Medical Administrators (RACMA). RACMA developed a "Queensland specific" curriculum for the development of leadership skills for Rural Generalists.

"It is imperative that Queensland's Rural Generalist workforce is well fitted to lead within the Queensland Health system; doing so in partnership with clinical

*colleagues in nursing and allied health professions as well as non-clinical leaders.”
(Dr Denis Lennox, Executive Director, Rural and Remote Medical Support, Darling Downs Health).*

To date, **46** Rural Generalists have undertaken the program after their Fellowship and have been conferred with Associate Fellowship of the College (AFRACMA). An Alumni group has been formed for these Rural Generalists to network, support one another and learn from each other. They also meet the College’s professional development activities that are required of them. A third cohort of **25** Rural Generalist Fellows will commence the program in early 2021.

The findings from the pilot project provided valuable insight into ‘Connection Primary and Secondary Care’.

Some considerations for the design of a Post Fellowship Support Model relating to these findings are displayed in Table 10.

Theme 1: Connecting Primary and Secondary Care Considerations for the Post Fellowship Support Framework
<p>Implement effective ICT systems</p> <ul style="list-style-type: none"> > Verify that processes are in place to ensure doctors are adequately introduced to local systems, trained to use the most efficient operating processes and supported to maximally utilise system functionality > Ensure ICT physical and infrastructure resources are satisfactory to meet contemporary healthcare needs.
<p>Working across Primary and Secondary care</p> <ul style="list-style-type: none"> > Promote strategies that foster encouragement of doctors working in general practices to work in hospitals and vice versa > Review current credentialing processes to identify opportunities to streamline the process to make it as efficient as necessary to ensure safe practice while removing redundant effort > Jointly work to develop suitable employment models, that enable rural doctors to work across primary and secondary health care settings. > Employers must make a commitment to offer flexible work arrangements and flexible rostering practices for doctors seeking to work as a Rural Generalist across primary and secondary care > Undertake a review of employment conditions, particularly as it relates to leave and professional development entitlements for doctors employed in general practice.
<p>Trust, Leadership and Culture</p> <ul style="list-style-type: none"> > Foster medical leadership development > Facilitate access to generic leadership training > Promote of rural-specific leadership training > Connect rural doctors to local medical leaders > Review how to recognise, enhance, encourage and support the leaders of today and tomorrow.

Table 10: Key support framework considerations pertinent to Theme 1

3.2 Valuing a Rural Career (Theme 2)

Introduction

This section introduces the results yielded from the components of the online survey and the semi-structured interviews pertinent to Guiding Principle 2 and 3: An overview of the relevant data collection sources is summarised in Table 11.

From the analysis of these findings, the primary theme '**Valuing a Rural Career**' emerged.

This comprised of two subthemes:

- Personal and professional factors; and
- Contributing factors

The theme, subthemes and contributing factors have been summarised in Table 12.

Whilst the findings in this section are not new and are expected, the interviews and survey results were a further confirmation of these sentiments.

Understanding the personal and professional factors that contribute to valuing a rural career is important because these factors influence career decisions, employment attraction and job satisfaction in the short and long term. An accurate understanding of the factors will also enable the factors to be incorporated into the design of a Post Fellowship Support Model.

Rurally based career paths are valued (Principle 2)

Job satisfaction is a critical element to working in rural and remote areas (Principle 3)

1. What are the things that have influenced your career decisions to date?
2. Rate on a scale of 0 to 10, how satisfied you are with your current work? (from '0 = Not at all satisfied', to '10 = Extremely satisfied')
3. Why did you give it that rating? Can you give both positive examples and areas for improvement?
4. What is it that makes you feel valued as a rural clinician?
5. What would keep you working as a doctor in this town?
6. If Queensland were to put into place a Post Fellowship Support Framework for all doctors, what do you see are some of the key elements of such a framework and how will it support you in your rural career into the future?

Table 11: Data collection sources: Interview guide and principles related to theme 2: Valuing a Rural Career

The pilot project provided an invaluable opportunity to canvas the views of current rural doctors about what factors influence their decision to continue working in a rural location, what impacts their sense of job satisfaction and what else is needed to ensure the rural

medicine career is a satisfying and ongoing one. Responses were received from doctors working across Queensland who varied in terms of chronological age and in terms of their personal and professional stages in life. This added to the richness of the data collected and increased the potential for the findings to be reflective of experiences across the collective rural workforce.

Theme 2: Valuing a Rural Career	
Guiding Principles	
<i>Principle 2</i>	<i>Rurally based career paths are recognised and valued</i>
<i>Principle 3</i>	<i>Job satisfaction is a critical element for working in rural and remote areas</i>
Subthemes	Contributors
<ul style="list-style-type: none"> ▪ Personal Factors ▪ Professional factors 	<ul style="list-style-type: none"> · Lifestyle and Community · Family Considerations <ul style="list-style-type: none"> - Schooling for children - Spousal employment · Positive Rural Practice · Variety of Practice · Work Conditions · Collegial Support

Table 12: Theme 2 with subthemes and contributions

The quantitative and qualitative findings follow.

Results

Quantitative Findings

Guiding Principles

Online survey respondents were asked to rate on a scale from one to five (1 = Not at all important; 5 = Extremely important) how important each Guiding Principle is for the design and development of a Post Fellowship Support Framework. The results relevant to the theme of Valuing a Rural Career are provided below.

Guiding Principle		Mean Rating (out of 5)
• Principle 2	<i>Rurally based career paths are valued</i>	4.36
• Principle 3	<i>Job satisfaction is a critical element in working in rural and remote areas</i>	4.64

The mean rating for each of the principles was greater than four (4 = Very important) indicating that survey respondents believed it was necessary to incorporate these principles

into the design and development of a Post Fellowship Support Framework. Compared to the mean score for all of the Guiding Principles, Guiding Principle 3 *Job satisfaction is a critical element in working in rural and remote areas* was rated the **highest** by rural doctors currently working in Queensland.

Qualitative Findings

Personal Factors

Lifestyle and Community

One of the most frequent comments provided about working rurally revealed an attraction to the lifestyle rural communities offered. The beauty of the land and the community was often stated.

"It's a great place to live out here... it's just beautiful... a beautiful oasis in the middle of the outback." (MS_F24).

Many respondents remarked that feeling part of the community was important and that the connectedness and relaxed nature of rural life was appealing to them. Doctors generally commented that they regarded themselves as fortunate to live and work in towns where a great sense of community exists.

"The town is really easy to live in. It's amazing to be able to walk my kids to day-care and then walk to work when I'm not on-call. It's lovely, an easy place to live." (GPSMO_H5).

Respondents also commented that when doctors live and work in a rural town, they are seen not just as service providers, but as valued members of the community, and this makes the experience of making a difference to the lives of people very real.

"You don't want kudos or thanks, because that's part of your job, but there's a good feeling that you're contributing to the community." (ED_F28).

There were many other powerful statements from doctors relating to 'feeling valued', and 'being appreciated'. Many of the doctors talked about being dedicated to their patients and their communities and feeling good about being part of or contributing to their communities, a vital retention issue for doctors.

Family considerations

Whilst many responses expressed positive aspects of a rural family-life, two family considerations in particular were negatively perceived and were repeated by several respondents. These considerations related to **educating children** and **sourcing suitable employment for doctor's partners**.

Schooling for children

Many doctors with a family valued a rural lifestyle for raising small children, but doctors with older children noted that educational expectations were increasingly difficult to meet in rural

areas as their children reached high school age. With the absence of suitable education options locally, doctors faced the choice of leaving rural practice or sending children away from the rural town to receive their education at boarding schools.

“The challenge, and I’ve seen these endless times, is education for the kids as they get on to 12, 13... I’ve seen people really agonise over it.” (EDMS_M17).

Due to the fact that enrolling children in boarding school is too expensive in many instances, some doctors who otherwise may have stayed in a rural location find it necessary to relocate their family. One doctor suggested that in these circumstances, where a Doctor has become part of a community over many years, offering of a subsidy towards meeting the cost of boarding school fees could be a good retention strategy for Doctors who don’t otherwise wish to leave their community.

Spousal employment

Rural doctors also commented that a lack of employment opportunity for their spouses continues to make it difficult to practice rural medicine. This was worsened recently during the pandemic. One doctor reported needing to relocate from one rural location to another because their partner’s employment had been terminated due to the economic downturn.

The data provided by rural doctors illustrated that support for the families of rural doctors is clearly a central issue of importance, as this appears to impact strongly on how long doctors are prepared to remain in rural areas.

“The downsides are certainly the on-call, and the volume of after-hours callouts has been really fatiguing and difficult to manage [especially] with a [medical] partner who does on-call and no family support.” (GP_SMO_H5).

Professional factors

Whilst personal factors can positively or negatively contribute to the value of a rural career, the data from the pilot project also demonstrated that professional factors also contribute to the value of a rural career. These were often related to experiences in the workplace including favorable employment conditions, a balanced workload and existing professional relationships.

Rural practice experiences

It has long been established that likelihood of doctors choosing a rural lifestyle and a rural career is often influenced by previous positive rural experiences. One doctor commented

“I am from a rural background...I loved my rural GP. What influenced my path to go rural, was that it is something I always wanted to do.” (GP_S29).

Another doctor reported that their decision to pursue a rural career was sparked by a positive undergraduate rural placement.

“There’s been a lot of influences including my first GP placement in a rural practice in my first year of Uni ... it was with a really good GP practice.” (GP_H18).

Widening the opportunity for doctors to experience rural practice may be the best advertisement for rural medicine. The ability for a positive rural practice experience to evoke a propensity for rural practice may not be restricted to only undergraduate or prevocational doctors but may also be an effective strategy to entice metropolitan doctors to give rural practice a try.

Practice variety

Many of the rural doctors indicated that they were attracted to rural medicine because of the variety of practice it affords. Doctors reported that rural medicine's broad scope of practice was both challenging but also very fulfilling.

"It's interesting work and it's rewarding clinically. It's got a lot of variety in it ... it is enjoyable. I like the fact that it's very broad and it's everything." (GP_VMO_M2).

"I can do obstetrics and emergency work and skin cancer and indigenous health and chronic disease and nursing home work and education all in one town, that's quite rewarding for me ...I couldn't imagine sitting behind this desk for five days a week. I would find that really hard." (DMS_C23).

As such, the wide scope of practice was considered a key contributor to job satisfaction for rural doctors. One doctor reflected that being able to do more for their patients was satisfying.

"Being able to do more for my patients [rather than sending them to the specialist] that's what gives me the satisfaction." (GP_M33).

Given the reported correlation between breadth of practice scope and attractiveness of rural practice, it was not surprising that actions that constrained the scope of practice available to a rural doctor were described by these doctors as regrettable. One doctor reported becoming 'deskilled' and experiencing a 'loss of procedural work' opportunities and that this had been a consequence of the heavy-handed trend towards specialist hospital-based services.

".. taking out an ocular foreign body? Go to an ophthalmologist. That's probably where we are heading, much to my dismay. I used to do a lot of stuff lots of fracture management, lots of reductions, but now we just refer up to ortho." (GP_VMO_M10).

Work conditions

Most doctors associated working in a rural location with strong job satisfaction and were not interested in a career change.

"I think it's the satisfaction of the job. I couldn't imagine doing anything else. I love what I do. I love it every day." (MS_S24).

But some rural doctors shared that they had experienced a reduced level of job satisfaction because of the pressure that came with the job.

"There's a lot of pressure for appointments, I guess you feel the workload." (PHO_D4).

This was typically related to busy workloads and the need to work overtime. Compounded by 'unpredictable afterhours that wear you out'. These factors reportedly led to fatigue which some

rural doctors claimed was an unavoidable part of practicing rural medicine. Insufficient general practice or hospital workforce was frequently cited as the cause of heavy workloads, long hours and frequent episodes of fatigue.

Several doctors reported that they were not financially motivated to follow a rural career.

“I think for me it was the lifestyle, it was the job satisfaction, it was never about the money.” (DMS_C23).

However, remuneration was often identified as another factor that influenced the value of rural practice with comments that patient Medicare rebates for services provided by rural GPs should be higher to appropriately compensate doctors for the service they provide, considering most primary care services in rural areas are bulk billed.

“You could spend 21 minutes with someone, or 39 minutes, and Medicare will give you the same amount of money. It’s an absolute joke because that’s just ridiculous.” (GP_VMO_G7).

Doctors also expressed dissatisfaction with professional advancement, access to training opportunities, time available to study professional literature and the ability to take quarantined holidays. These comments were predominantly provided by GPs rather than hospital doctors. One of the possible reasons for this may be that hospital doctors have policies in place that cover employment conditions like fatigue management, professional development leave, etc. This will be discussed further in section 3.3 and 3.4 but suffice to say that employment conditions were clearly reported as factors that influence job satisfaction and the sense that a rural career is valued.

Collegial support

Doctors identified collegial support as a critical success factor for valuing a rural career. Towns where doctors were able to work with supportive colleagues, like cross-sectoral teams that collaborated in a respectful and friendly way, where specialist staff were approachable and where there was access to more experienced doctors were all examples of factors that doctors considered when deciding to seek and maintain rural employment.

“All the support of colleagues ... it’s an amazing team that we have here, the people are extremely supportive and extremely knowledgeable, it’s a nice thing.” (GP_VMO_N11).

One senior doctor reflected that when professional support and good-will abound, even challenging events like a pandemic can improve how teams work together.

“I love this place because of the team, despite the fact that we are stressed, we do have a bond of some sort. Even [during] the challenge of the current times, I would guess that we have bonded even more.” (EDMS_S31).

The power of working with good people in a supportive collegial environment where doctors are encouraged to learn from each other was recognised as being key to ensuring staff retention for years into the future

“I have met some really fantastic people. And you’d look at their practice and think, that is really good practice and take on board what they were doing.” (GP_VMO_M10).

Achieving work life balance

The dichotomy in rural medicine of doctors loving the work they do but struggling to balance competing demands in a way that allows adequate time for parenting, recreation and recuperation was raised by some doctors. This was particularly relevant to doctors with young families and doctors from younger generations. An early career doctor commented:

“To have that work life balance is a big thing for our generation as well is trying to have that a bit more.” (GP_SMO_G9).

Achieving balance was identified by doctors of all ages and experience levels as being difficult to attain. Commonly cited barriers to reaching this balance was insufficient staffing levels, roster rigidity, work intensity, on-call frequency and inability to easily secure locums to cover periods of planned leave.

Discussion

The second theme to emerge from the findings was ‘Valuing a Rural Career’. Analysis revealed that attraction to a rural lifestyle was the main factor in a doctor’s decision to pursue a rural medical career, immediately followed by the variety of practice that rural medicine brings and the relationship with the community and patients that develop when living and working in a rural community. The overall sense provided by doctors participating in the pilot project was that rural practice offered sound job satisfaction.

“The job that I have here is perfect, it’s exactly as it was advertised and that’s pretty much it.” (GP_SMO_H5)

However, doctors also described factors which corrode the value of a rural career, some of which were more commonly reported by GPs than doctors engaged in the hospitals. The findings from the pilot project suggested that valuing a rural career can be positively influenced by accommodating some key personal and/or professional factors.

Analysis of the findings related to Valuing a Rural Career were arranged under two subthemes, each of which identified contributory elements that enabled or inhibited the success of valuing rural practice.

The first subtheme, **personal factors**, described how lifestyle and family circumstances can impact the value of a rural career.

The findings revealed that the lifestyle offered in rural towns was the strongest factor that influenced a doctor to enter or remain in a rural career. Rural life was reported to offer a relaxed pace with minimal commute and an abundance of recreational options. The sense of community that is inherent to rural life was also highly regarded; respondents reported they appreciated feeling valued for the work they do, being able to see that the work they do makes a difference and knowing that they are contributing to the good health of the people living in their community. Living and working in a rural or remote location was reported to be particularly suited to early family life.

While country life was viewed by rural doctors as conducive to family life, they also acknowledged that some family factors made it difficult to move to or remain in a rural location.

The two main components described in the findings related to the education of children and the employment of partners, as mentioned previously. Doctors described personally experiencing

or being counseled by senior rural colleagues about the challenge of finding local schooling that was matched to the educational options these doctors desired for their children. This was a problem that became more pressing for doctors as their children approach high school age. Doctors lamented the need to choose either to depart the rural town they had worked in for many years or to endure the financial and emotional strain associated with separating children from the family so they can attend boarding school in another location. Though little can be done to change the educational opportunities available to children living in rural and remote communities, support could be provided to doctors who are willing to continue practicing rurally while their children attend boarding school if a solution was forthcoming to address the financial disadvantage experienced by doctors who make this decision.

A suggested strategy is to investigate options that would reduce the financial impact on rural doctors who continue to work in a rural location while accepting the extra educational costs incurred to ensure their children receive the desired type of schooling. Initiatives like boarding school fee subsidies or free travel for children between the rural town and the boarding school they attend may incentivise rural doctors who would like to continue their rural career but would otherwise be unable to do so without financial support.

Another barrier to undertaking or continuing a rural career reported by doctors was the ability for their partners to secure reasonable employment. Examples of doctors, who were otherwise happy to live and work in a rural location but made the decision to leave because no work option were available for their spouse were provided by some respondents.

A suggested strategy is to assist doctors' partners to find employment. Consideration could be made to inviting both husband and wife to discuss the rural employment opportunity before finalising employment offers.

The second subtheme, **professional factors**, demonstrated that promoting rural practice placements, enabling doctors to work to their full scope, ensuring manageable workloads whilst providing generous employment conditions, fostering collegial support and prioritising work-life balance were all enablers to valuing a rural career.

It was well acknowledged that having a positive experience working in a rural location was powerful at generating interest in a rural career. This was reinforced by the findings of the pilot study which included examples of when the opportunity to receive first-hand experience of rural life or rural practice led to doctors choosing a rural career. The finding that a rural experience increased a doctor's propensity for a rural career suggested that more should be done to leverage this enabler.

A suggested strategy is to maximise the number of, and ease of access to, opportunities for training and graduate doctors to experience rural practice.

Rural medicine was viewed as a career that had much to offer doctors willing and prepared to experience variety in their day-to-day working life. In fact, the variety of the work required to be undertaken in rural medicine was the second most important factor identified by rural doctors as contributing to the success of valuing a rural career.

However, some rural GPs reported seeing a trend towards the development and utilisation of an increasingly specialised medical workforce where doctors were required to complete additional formal training that was generally delivered in a hospital setting and rarely offered in rural locations. They reported difficulty finding appropriate locums to cover the general practice while the local GP travelled to undertake training. Then there is the additional challenge that a GP does not generate an income while out of the private practice to complete training or upskilling. These factors made attaining or maintaining additional skills more difficult for GPs

than hospital doctors. They observed that this had led to a decrease in the volume of procedural services being provided by doctors in general practices and an increase in these services being provided by hospital doctors. The loss of admission rights for their private patients into the local hospital and reduced opportunities to perform procedural work was reported by GPs to have led to lessening of both their scope of practice and their level of job satisfaction.

Noting the correlation between job satisfaction and the ability to attract and retain rural doctors, the findings suggested that more needs to be done to ensure all doctors can safely practice across a broad rural practice scope.

A suggested strategy is to promote equal opportunity for GPs and hospitalists to undertake additional training requirements to increase their scope of practice. These efforts should be undertaken in parallel, with efforts to remove the barriers that prevent doctors, especially GPs, to work to their full scope.

Doctor shortage, the strain of juggling long hours and not enough rest has generally been accepted as increasing the levels of stress and fatigue placed on rural doctors. ***“Medicine in Australia: Balancing Employment Life (MABEL)”*** survey data [9] notes that rurality increased the number of hours a doctor works (procedural GPs in MMM 7 locations work 46.3 hours per week compared to 39.9 hours per week in MMM 1 locations). There was also a variance in the number of days on-call, with procedural GPs in MMM 7 locations found to be on-call approximately 1 in 4.7 days and on-call for hospital work approximately one in 2.4 days.

It was recognised in the pilot project findings, that rural doctors continue to contend with the realities of staff shortfall leading to long working hours, voluminous on-call periods and heavy workloads. Doctors described these factors as contributing to fatigue, poor work/life balance and reduced job satisfaction. GPs added that this was compounded by inadequate Medicare rebate values, limited career structure and professional development and leave entitlements that were inferior to the employment conditions offered to hospital doctors. Some doctors reported that the financial reward for rural medicine was too low and failed to reflect the value of rural practice. Some GPs remarked that hospital doctors earn more than GPs and that it seems much easier for hospital doctors to obtain professional support.

These pilot project findings highlighted that despite the implementation of various rural initiatives led by the Commonwealth and/or Queensland Governments, the solution for achieving optimal rural medical workloads and work conditions has not yet been achieved. The findings also revealed an emerging divide between primary and secondary providers where the workload and work conditions of doctors working in primary care are viewed to be different to those of doctors working in secondary care. Some doctors reported a concern that the introduction of the NRGPs would introduce a further medical workforce divide in the rural sector.

Despite the concerns expressed by doctors about chronic workforce deficits, long hours and restricted practice scope, most doctors identified that the negative effect these caused could be offset by the sense of support that comes from being part of a network of colleagues and friends that can call and be called upon when needed. This finding illuminated the enormous value that rural doctors place on professional support.

The pilot project provided a unique insight into Valuing a Rural Career from the vantage point of those working in this area. The findings confirmed that rural doctors enjoy living and working in rural communities, but that job satisfaction can be negatively impacted when inhibitory personal and/or professional factors arise. However, the findings also showed that when the community and the workplace support the personal and professional factors that enable job

satisfaction, rural doctors were more likely to be attracted to and continue to live and work as part of a rural community.

Learnings related to how a Post Fellowship Support Framework could positively impact Valuing a Rural Career and the components that doctors said should influence the design and development of the framework are discussed in Table 13.

Theme 2: Valuing a Rural Career Considerations for the Post Fellowship Support Framework
<p>Support for Doctors’ Families</p> <ul style="list-style-type: none"> ➤ Promote the potential for family member/s to secure appropriate employment locally ➤ Seek and maximise incentives or initiatives that will enhance secondary school educational opportunities for familymembers.
<p>Build Rural Generalist Workforce Capacity</p> <ul style="list-style-type: none"> ➤ Leverage the ability of rural immersion terms and experience in encouraging and supporting doctors to be trained to embark on rural careers ➤ Identify opportunities for and streamline the process to complete any additional training necessary to increase scope ofpractice ➤ Facilitate access to qualified locum and / or reliever services. Guide the discovery of initiatives or incentives available to lessen the burden of relief services ➤ Verify that training is available and provided to assist doctors to optimally rearrange. their businesses and to provide business acumen ➤ Review the approach to succession planning to confirm it will meet the current and emerging workforce needs.
<p>Professional Support</p> <ul style="list-style-type: none"> ➤ Ensure rural doctors are aware of how their employer/sector provides professional support ➤ Ensure that rural doctors know how to express a willingness to provide support to other doctors in their place of employment/sector ➤ Direct rural doctors to available support mechanisms ➤ Promote the culture of seeking and providing support if and when relevant ➤ Review current processes to enable ongoing professional support for rural doctors ➤ Maximise the support roles that mature rural doctors can play in offering collegial support for less experienced rural clinicians ➤ Employers should seek to enhance supervisor / mentor capability within their workforce and investigate any opportunity to access and provide this capacity widely.

Table 13: Key support framework considerations pertinent to Theme 2

3.3 Supporting Training and Education (Theme 3)

Introduction

This section introduces the results yielded from the components of the online survey and the semi-structured interviews pertinent to Guiding Principles 4, 5, 7 and 8: An overview of the relevant data collection sources is summarised in Table 14.

From the analysis of these findings, the primary theme '**Supporting Training and Education**' emerged.

This comprised of two subthemes:

- Training challenges unique to rural medicine, and
- Enhancing training for rural doctors.

The theme, subthemes and contributing factors have been summarised in Table 15.

Much has been published about the importance of training and education for rural and remote doctors and the need to build the capacity for these doctors to complete advanced rural skills training [see e.g.11, 12, 13, 14]. Yet no data is available that specifically looks at this in the context of attaining the NRGD endpoint.

The aim of the NRGD is to develop a skilled workforce of rural doctors who can work across the range of comprehensive primary care, secondary care and other specialist care areas that rural communities need. It is both a training and workforce framework that delivers rural-based training and forms a basis for considering recognition of prior learning and lateral entry options into the Rural Generalist discipline [2].

As it stands, the NRGD will have nationally consistent 'endpoints' as agreed between the two training colleges, RACGP and ACRRM. The 'endpoint' is based on the Collingrove Definition which integrates General Practice, Emergency Services and Additional Skills to reflect the diverse needs of rural communities. A particular consideration in developing the pathway was to identify 'the right fit of generalist training [2] and to ensure current GPs receive the support they need to attain and maintain additional skills to meet the Rural Generalist definition.

Currently in Queensland, additional skills are referred to as 'advanced skills' and are acquired by successfully completing Advanced Skills Training (AST) through either ACRRM or RACGP. Successful AST completion takes 12 months (except surgery which is a two years advanced skill in Queensland) and may be procedurally based (for example anaesthetics or emergency medicine) or non-procedural based (for example adult internal medicine, paediatrics or mental health). Doctors who are procedurally trained may be credentialled to work in rural hospitals [12]. Many of the doctors interviewed, reported that they work across a broad scope of practice having successfully completed the QRGP or college curricula to achieve FACRRM or FRACGP / FARGP qualifications.

The ability to attain advanced skills is supported to meet community needs (Principle 4)

1. [An important part of developing the NRGPs will be supporting GPs to attain and maintain advanced skills.] Have you completed your advanced skills training?(Y/N)
If no,
 - a. have you ever considered pursuing advanced skills training?
 - b. If so, what skill would that be and why?
 - c. If not, what are the reasons for not pursuing advanced skills training?**If yes,**
 - d. what are your skills? _____
 - e. Are you able to use those advanced skills in your current role?
 - f. Can you meet the requirements for maintenance of this scope of practice?
2. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, what would you see is its role in supporting your advanced skill or influencing you to do further skills training?

The ability to attain, maintain and upgrade procedural skills is supported to meet community needs (Principle 5)

1. How do you maintain your procedural knowledge / skills?
2. How can support for procedural skills in general practice and hospital settings be developed to encourage medical practitioners to obtain procedural skills that meet the needs of your community and practice?
3. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, what role would you see it performing to encourage, obtain, maintain and upgrade your procedural skills?

Education and training needs are supported (Principle 7)

1. How would you rate from zero to 10 the ability for you to undertake educational activities in / from your town? (0 = No support and 10 = A lot of support)
 - a. Why did you give it that rating?
2. In your opinion, what is working or what could be done to improve educational support in your town?
3. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, how might the framework enable improved educational support?

Professional peer support is respected, valued and available (Principle 8)

1. How would you rate from zero to 10 the support from your professional peers in your town? (0 = No support and 10 = A lot of support)
 - a. Why did you give it that rating?
2. In your opinion, what is working or what could be done to improve professional support in your town?
3. If Queensland were to put in place a Post Fellowship Support Framework for all doctors, how might the framework enable improved professional peer support?

Table 14: Data collection sources: Interview guide and principles related to Theme 3: Supporting Training and Education

The mixed methods approach enabled the pilot project to extract a wealth of information about the attitudes and experiences doctors working in rural and remote locations across Queensland have in relation to training and education. It also afforded the project team the ability to seek information specific to the question of what role a Post Fellowship Support Framework could play in assisting rural doctors to provide the diverse primary and secondary healthcare needed by people living in rural and remote locations.

Theme 3: Supporting Training and Education	
Guiding Principles	
<i>Principle 4</i>	<i>The ability to attain advanced skills is supported to meet community needs</i>
<i>Principle 5</i>	<i>The ability to attain, maintain and upgrade procedural skills is supported to meet community needs</i>
<i>Principle 7</i>	<i>Education and training needs are supported</i>
<i>Principle 8</i>	<i>Professional peer support is respected, valued and available</i>
Subthemes	Contributors
<ul style="list-style-type: none"> ▪ Training Challenges Unique to Rural Medicine 	<ul style="list-style-type: none"> · Cost: Time and Financial · Training Option Flexibility · Management Support
<ul style="list-style-type: none"> ▪ Building Capacity for Rural Doctor Training 	<ul style="list-style-type: none"> · Locally available training · Mentoring · Coordination Unit function

Table 15: Theme 3 with subthemes and contributors

The quantitative and qualitative findings are discussed below.

Results

Quantitative Findings

Guiding Principles

Online survey respondents were asked to rate on a scale from one to five (1 = Not at all important; 5 = Extremely important) how important each Guiding Principle is for the design and development of a Post Fellowship Support Framework. The results relevant to the theme of Supporting Training and Education are provided below.

Guiding Principle		Mean Rating (out of 5)
• Principle 4	<i>The ability to attain advanced skills is supported to meet community needs</i>	4.43
• Principle 5	<i>The ability to attain, maintain and upgrade procedural skills is supported to meet community needs</i>	4.53
• Principle 7	<i>Education and training needs are supported</i>	4.52
• Principle 8	<i>Professional peer support is respected, valued and available</i>	4.30

The mean rating for each of the principles was greater than four (4 = Very important) indicating that survey respondents believed it was necessary to incorporate these principles into the design and development of a Post Fellowship Support Framework.

Qualitative Findings

Training challenges unique to rural medicine

When the data provided by respondents related to Supporting Education and Training was analysed, many of the responses described training challenges that impact doctors working in rural and remote locations more than doctors working in regional and urban areas. The key contributors to the subtheme of training challenges unique to rural medicine are discussed below.

Cost: time and financial

The cost to complete additional training was commonly reported as being a significant challenge for doctors working in rural and remote locations. Rural doctors described that the cost to travel from their place of residence / employment to the training site was higher than it was for colleagues traveling from regional locations with ready access to discount airfares or for those working in metropolitan areas where the commute could be completed by road. Primary care providers described the additional financial impact due to being out of the private practice and not generating revenue while they travelled for and undertook additional training.

“Access to paid education for GP’s is a gaping gap ... GPs are self-employed and as such we take a financial loss every time we take time off for further education. This is a strong disincentive to up-skill further and needs to be addressed.” (S_15).

GPs explained that this financial impact was compounded by the requirement to use locum services. Cost here was incurred through consultation time that was lost while they instead spent time arranging locum cover to ensure the community had reasonable access to primary care while the rural doctor was absent for training purposes. Significant cost was also incurred by having to pay for the locum service. It is also not an unfamiliar situation that regular patients hold off seeing locums until their GPs return, unless it is an emergency or a pressing need – this leads to lower revenue in the practice that sometimes does not cover practice overheads during the regular GPs absence.

"I can't afford it ... locums are like two grand, three grand a day. I can't afford that. It's not viable." (GP_S29).

It was reported that more often than not that the training occurred over several days which required overnight stays (away from family and loved ones) and this added to the personal cost of undertake training.

Some participants acknowledged the Commonwealth rural incentive payments that were available to undertake training e.g. the Rural Procedural Grants Program that offers a grant subsidy to partially offset the costs associated with attending training to maintain and enhance procedural and emergency medicine skills. Another example is the grant for GPs to attain procedural skills specifically in anaesthetics and obstetrics.

However, the responses provided by the respondents showed that whilst Commonwealth incentives for rural doctors to complete additional training exist and have improved over time, the available incentives have not been shown to satisfactorily compensate rural doctors for the high cost of undertaking advanced or procedural training. As such, the cost of training continued to be reported as a significant obstacle to doctors.

Training option flexibility

Doctors shared that time constraints on acquiring and maintaining skills are inherently restrictive [14] and that the process for obtaining an advanced skill lacked the flexibility needed to be achievable for those working in busy practices. They also commented that the current training programs for advanced skills training, lacked the agility required to accommodate the changing demands and priorities of rural doctors as they progress through the many stages of their personal and professional lives. Some examples of rigidity cited by the doctors related to the restrictions on the timing and location of available training. Some doctors insisted there needs to be a flexible curriculum. As one GP commented:

"Set a curriculum that is achievable for someone like me in private practice, and a set timeline, with an achievable goal." (GP_VMO_M10).

The results of the pilot project demonstrated that training programs designed to provide rural doctors with additional skills need to be adaptable in terms of the way and the time that they are available so that rural doctors can achieve the acquisition and maintenance of additional skills that are relevant to the communities they serve in a manner that causes least disruption to the doctor's work and home life. Further, the same doctor stated that if GPs are going to undertake an AST in an area that meets their community's needs, there needs to be more flexibility in how training standards are achieved:

"Having a pre-set curriculum and guidelines as to what you can do, so you can commit knowing what you're up for, having set endpoints, attainable endpoints." (GP_VMO_M10).

Management support

Responses in the study suggested that hospital and general practice doctors living and working in the same rural and remote communities have access to different support mechanisms that management oversee. Access to paid leave for training purposes was one example provided. The data suggested that it is more difficult for GPs to successfully complete additional training

and to utilise and maintain their additional skills than hospital doctors. This had resulted in a level of concern by some doctors that working arrangements and engagement models for hospital doctors might positively bias their ability to meet the NRGF endpoint compared to rural GPs.

The unintended consequence of this is that it could widen the gap between the perceived value of primary care provided by rural GPs who have attained their Fellowship as compared to Rural Generalists engaged by hospitals (at a substantially higher industrially accepted salary scale in Queensland) for doing similar primary care duties.

“As a private GP I do not have access to any paid study. This is a major disincentive to up-skilling. The national framework will focus too heavily on hospital-based services at the expense of general practice (both in funding and support). If general practice is weakened relative to hospital services, it will result in higher demand for hospital services as general practice is neglected. I currently work 50+ hours per week in general practice plus on-call and in doing so prevent 150+ patients per week from needing to attend our small rural ED; this needs to be acknowledged and reimbursed adequately and not seen as being 'lesser' than doing shifts in ED which would ironically reduce my ability to see patients and likely result in more ED attendances.” (GP_S_p567).

The requirement to provide emergency care as part of the Collingrove Definition was noted to be a potential challenge for some GPs. Management support and cross-sector cooperation will be required to ensure GPs who wish to work to the Rural Generalist definition are provided with the opportunity to work in ED and maintain their skills, such as airway management. One doctor, working in a remote part of Queensland, noted that all GPs would benefit from having an advanced skill, however emergency skills such as airway management should be core practice of rural and remote doctors with the requirement to upskill in an emergency department for a week a year

“Really, you need to be able to manage an airway and any acute emergency as a rural and remote doctor. ...So [upskilling] at least a week in an emergency department once a year is a fair requirement.” (DMS_B14).

Building capacity for rural doctor training

The second subtheme to emerge from the analysis of data provided by respondents about Supporting Education and Training was building capacity for rural doctor training. The key contributors to this subtheme are discussed below.

Locally available training

The most common detractor for undertaking CPD activities was reported to be ‘lack of time’ caused by busy caseloads. As one doctor noted:

“[To] try and keep up to date with everything else in general practice is a Herculean task.” (GP_VMO_G7).

The time commitment necessary to complete training was then compounded by the need to travel vast distances to access the opportunities.

Respondents offered that being able to complete training closer to where they live, and work would make undertaking the training more attractive.

Rural doctors participating in the pilot project asserted that some or all components of their procedural training and professional development should be provided onsite. They discussed a preference for locally led and delivered education such as 'simulator-based training' using local learning scenarios which, apart from being relevant to the needs of their communities, also afforded the opportunity to practicing communication and teamwork skills, sometimes with cross-sector colleagues.

"The main advantage of simulation is teamwork because you put teams together in a simulation and then critique them as a team." (EDMS_M17).

It was noted that new virtual educational technologies and modules are increasingly being used to overcome the tyranny of distance, but that additional benefits were gained by participants when they also allowed clinicians who work together to train and work as one team. This was particularly powerful when training doctors in rural and remote areas.

Doctors commended the training entities that were beginning to take their education programs to rural towns to make them more accessible to doctors practicing rural medicine. One example offered was the Queensland Emergency Medicine Education and Training (EMET) course that provides education to clinicians working in emergency care in non-metropolitan areas (across Australia) who are not specifically trained in emergency medical care.

"EMET comes to us, which is fabulous." (GP_VMO_G7).

Another example provided was the Practical Obstetric Multi-Professional Training (PrOMPT) provided by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), a multi professional obstetric emergencies training package for use in local maternity units with the aim of reducing preventable harm to mothers and their babies.

"We run Prompt here [in our rural town] ... so that's great we get to do that stuff here in [X]." (GP_VMO_G7).

Mentoring

It was acknowledged that a career in rural medicine and a sense of professional isolation often go hand-in-hand and that the professional support of greatest value was that which only someone who has walked the walk of rural medicine can offer. It was not surprising then that ready access to professional support from another rural doctor was considered vital by respondents. Respondents commented that rural doctors tended to take a vested interest in one another because only rural doctors truly understand each other's unique situation.

"With respect to my other experienced rural GP colleagues, we back each other up very well. But that's not a new thing, country doctors have always done that." (GP_VMO_M2)

Evidence of appreciating the value of peer support was observed by doctors across the rural career spectrum, from registrar to seasoned doctors. As one doctor said:

“A structured mentoring program for all clinicians, wherever they sit in the hierarchy. It’s not something, pushed into seven o’clock before dinner. It would pay enormous dividends.” (DMS_B14).

The responses suggested that while all types of peer support are important, a formally nominated mentor with longer country service than the rural doctor mentee is particularly valued.

“I’m missing having an actual designated mentor. That would be helpful for personal, professional and academic reasons. Someone who is five to ten years further along.” (GP_SMO_H5).

This was further illustrated by the example from a doctor who saw having designated mentor as a way to foster the practice of escalating concerns to the right person, at the right time, confident in the knowledge that there was somebody to talk to when you had problem.

“Because the danger in all these situations is when you become a post-fellow ... that you can sometimes have issues that can fall upon deaf ears or have no one to escalate to. So, there needs to be somebody to talk to if you have problems.” (RMO_S13).

Several doctors noted that they would benefit from mentoring support and asserted that a Post Fellowship Support Framework could incorporate mentoring through a structured mentor program which, in the words of one DMS, would:

“Pay enormous dividends.” (DMS_B14).

Another experienced VMO said:

“Coordinate opportunities to network and share with other rural doctors. Especially for the new fellows, talking to the more experienced GPs, rural doctors, that’s really important ...it doesn’t take that much time to chat to someone who is just starting off in [X] or wherever, and saying, “how’s it going?” ... it’s an opportunity to be in touch with another doctor doing this work and it’s good.” (GP_VMO_M2).

Coordination Unit function

When questioned about what they perceive would be the role of a coordination unit in regards to education, many saw great merits in a unit that coordinates the training that they require in their town or as locally as possible, sources the relevant speakers / educators, and allows seamless ability to satisfy their CPD requirements. This will save time and frustration for doctors who require to fulfil their CPD requirements or need upskilling.

This burden of organising their own CPD activities was routinely quoted as a major inhibitor to accessing appropriate CPD. One doctor confessed:

“The bit I probably find the most overwhelming at the moment is the logistic planning about trying to do some upskilling.” (GP_VMO_G7).

Doctors provided a variety of suggested functions that a Coordination Unit could perform to alleviate the load they carried when seeking and completing required training and education. Many doctors related that establishing a Coordination Unit was paramount in creating a central repository of planned training and education. Doctors advocated that this type of initiative would mean they would be able to access all requested training opportunities that they have

flagged as suitable for their needs, rather than the current practice of laboriously scrolling various platforms in search of specific training opportunities, courses and conferences.

"It's a little bit of an effort to find it [upskilling] and go through the steps to organise that stuff." (VMO_GP_M2).

An example was provided by a respondent to highlight how the Coordination Unit could assist a doctor wanting to undertake advanced skill training in mental health. The doctor proposed that he could advise the Coordination Unit of this request to complete mental health training and the dates on which the doctor is available for training. The Coordination Unit could then source the specific training in a location and within the range of dates requested by the doctor.

"To do secondary skills in mental health is difficult and I think that there would be a significant role for an organisation to assist with helping the step between a GP or a post-fellowship GP trying to find somewhere to do some more training." (RMO_S13)

Another proposed function of the Coordination Unit was to identify and/or negotiate suitable clinical attachment opportunities; and then take the steps necessary to arrange for this quarantined training.

"One of the biggest problems that doctors have is getting away to do is a clinical attachment, and I think the [Coordination Unit] could definitely support clinical attachments." (DMS_C23).

Several practitioners pleaded for a solution that would offer rural clinicians guaranteed access to an upskilling post, so that doctors wishing to upskill are rostered on duty, rather than being supernumerary. This would avoid the risk that "you'll stand in the corner for the whole week" having to compete with other health practitioners in their training requirements also.

To that end, one doctor working in remote Queensland suggested that the main function of the Coordination Unit would be to 'broker' with tertiary hospitals to identify upskilling opportunities and then publish these training / education opportunities so that doctors can identify where and when training / education would be suitable to meet their specific training needs.

"Almost like an Airbnb." (SMO_C16).

In order to achieve the end of '*minimising the paperwork*', while ensuring:

"It [navigating the NRGF endpoint] is smooth, not have to climb Mount Everest to do it." (ED_F28).

Some doctors espoused that the Coordination Unit could influence current credentialing processes. It was propounded that the Coordination Unit could undertake to advocate for a standardised (credentialing) process, streamlined to facilitate portability of credentials in advanced procedural skills across hospitals and stated that such a coordination unit would serve as:

"An office that can coordinate the application for credentialing that often is required, to streamline the way that doctors work." (DMS_C23).

Finally, the function of the Coordination Unit was described as a way to:

“Supporting us in maintaining our tick boxes essentially.” (SMO_C3).

Discussion

Supporting Training and Education was the third theme to emerge from the findings. The findings provided a rich insight into the barriers, challenges and support needs of doctors working in rural and remote locations. These were considered through the lens of the NRGP and what would be needed for doctors to practice in a manner that meets the Collingrove Agreement definition of a Rural Generalist.

Access to continuing education and professional development is necessary to maintain competence and improve performance of health professionals [15].

The data analysis as a result of this project clearly demonstrated that rural doctors were willing to support a commitment to the NRGP but, at the same time, were united in their concern that it would be difficult to do so without making changes to the way doctors were supported to prioritise, complete, use and maintain required additional skills. According to the information provided by the doctors living and working in rural and remote communities across Queensland who participated in the pilot project, the theme of Supporting Training and Education could be maximised by addressing the contributory factors associated with the subthemes of *training challenges that are unique to rural medicine* and *building capacity for rural doctor training*.

When discussing the subtheme of training challenges unique to rural medicine, the findings described time and financial costs that rural doctors had to bear in order to participate in training opportunities. It showed that the accumulative expense routinely rendered the attainment and maintenance of additional skills unviable or impractical. It highlighted the need for increased flexibility in where, how and when training programs for advanced and/or procedural skills were delivered. It also reinforced the essential role of management in removing or reducing workplace challenges, employment conditions or cultural factors that made it more difficult for doctors needing to complete training and maintaining additional skills to do so.

The main barrier to completing CPD was reported to be ‘time’. As discussed in section 3.2, practicing rural medicine was usually accompanied by busy caseloads and long work hours. For rural doctors, the time cost of completing CPD was impacted by the geographic distance between their place of work and the training site, and the hours required to troll through multiple mediums to find the training required that matches the date range suitable to the doctor. The time taken to source a locum to cover the period of training was also mentioned as was the loss of personal time that would otherwise have been spent with family and loved ones had the doctor not needed to travel to/from for attendance at the education and training event.

Financial costs identified by rural doctors in addition to training costs included loss of revenue because the doctor was away from the practice, transport costs that tended to be charged at a higher rate than the rate charged in larger communities with greater transport choice

(e.g. multiple flights with more expensive regional airlines) and the cost of locum fees paid to maintain a service while the usual doctor was attending training.

A suggested strategy is to reduce the cost burden on rural doctors who want to achieve the NRGF endpoint and who require additional training to do so.

Many of the doctors who participated in the pilot project mirrored the findings from other studies that doctors currently working in rural Australia intend to remain there for several more years, and this provides strong evidence of the requirement for focused support strategies to sustain the long-term rural commitment of both GPs and doctors employed at hospitals. [16].

The ability to acquire and maintain advanced skills at any stage in a GP's career is vital in ensuring a resilient multi-skilled GP workforce able to meet location specific service gaps and tackle the challenges of rural general practice [11,12,13].

The findings from this pilot project indicated that access to a flexible training pathway and a flexible funding solution would be required for private rural GPs to meet the NRGF endpoint.

Throughout the project, doctors expressed concern about the lack of flexibility in the current advanced skills training programs. They insisted that if doctors who has already achieved Fellowship of either college were to be encouraged to meet the NRGF endpoint, training programs would need to be flexible and respond to the fluxes that occur over the duration of a doctor's career, as the doctor responds to changes in their community, or the doctor's circumstances change. The training programs would also need to be agile enough to allow GPs to gain the additional skills they need, at a time that is appropriate for them. The claim that current time constraints on acquiring and maintaining skills, and access to training away from home, are inherently restrictive [14] was reiterated by the findings from the pilot project. To this end, it was considered pertinent that colleges and training providers find effective ways of supporting GPs and other rural doctors wishing to attain an advanced skill.

A suggested strategy is to recognise and incorporate opportunities to increase the flexible and customisable nature of College-led advanced skill training. Focus should begin by exploring opportunities to modify the time constraints of and the need to travel to complete advanced skill / procedural training. This will require cooperation between sectors and training colleges.

Medical workforce managers were frequently cited as holding the requisite level of influence to effect change that would reduce the challenges rural doctors face when seeking to obtain or maintain additional skills to meet the needs of their community.

A suggested strategy is to proactively seek, wherever and whenever possible, local, or near local, training and education solutions and to advocate for strategies that removes the inequality or excess cost in the ability to participate in CPD activities that currently exists for private rural GPs as compared to hospital doctors engaged under favourable industrial agreements.

When discussing the subtheme of building capacity for rural doctor training, the findings described the value a Coordination Unit would bring in the provision and organisation of targeted locally led training events. It showed that although more CPD opportunities were available to doctors through a widening array of mediums (e.g. COVID-19 forced virtual learning

offerings), time to complete training continued to be limited. It also demonstrated how locally conducted training that was delivered collaboratively in a collegiate manner for all to attend in isolated areas had not only achieved the training endpoint but also strengthened professional relationships.

A suggested strategy is to prioritise training opportunities that are organised across sectors and delivered onsite and within easy travelling distance, and the opportunity to undertake that training be available to all the doctors that actually provide a service in the town

There was unanimous support for the concept of a Coordination Unit with multiple suggestions provided to describe the functions it could perform to support training and education for rural doctors. It was suggested that the Coordination Unit could address some of the major barriers to training. A commonly suggested function was to provide the platform for planned training to be organised and advertised in a way that easily directed doctors to the training they were seeking and could effortlessly match available options to the date range suitable to the requesting doctor/s. Other functions included coordinating credentialing requirements and taking responsibility for securing an AST training location. The coordination of mentoring for all rural doctors was also proposed as a valuable Coordination Unit function.

A suggested strategy is to determine which functions the Coordination Unit will be responsible for and which functions are already being performed by other stakeholders to avoid duplication.

The literature has long demonstrated mentoring as a useful and positive experience for supporting a broad range of a clinician's personal and professional development needs [19]. During the pilot project, a desire to access mentoring and peer support was identified by doctors at all levels of experience. These doctors described the special challenges of rural medicine and remarked that very few other people are better able to provide useable advice about work life balance, career development and rural work/life issues than a doctor who has actually lived the life of a rural doctor. Some experienced rural doctors expressed a willingness to mentor less experienced doctors and noted that they receive almost weekly calls from colleagues or peers asking for mentoring advice, seeking someone to listen to or requesting help with professional, educational or personal concerns. The need to establish a peer mentoring network was mentioned on multiple occasions during the pilot.

A suggested strategy is to determine the ability to establish a peer support network and the feasibility of maintaining this. Consideration could be given to what role the Coordination Unit may perform in this regard.

Overall, strong interest in Supporting Training and Education was shown by pilot project participants. The findings confirmed that rural doctors are eager to obtain and maintain the training necessary to provide the comprehensive primary and secondary health services needed by their community. Generally, rural doctors supported the NRGPs, although some caution was exercised by rural GPs who were less confident that their position outside the hospital industrial environment would lend to easy ability in attaining and maintaining additional skills.

Enthusiastic support was provided by doctors when discussing the potential functions of a Coordination Unit to remove some of the barriers preventing doctors from undertaking additional skills training.

Findings related to how a Post Fellowship Support Framework could positively impact

Supporting Training and Education and the components that doctors said should influence the design and development of the framework are discussed in Table 16 and are also displayed in Appendix 8.

Theme 3: Supporting Training and Education Considerations for the Post Fellowship Support Framework
<p>Support for training costs</p> <ul style="list-style-type: none"> ➤ Facilitate easy access to available funding sources ➤ Provide direction to potential locum / reliever options.
<p>Flexible advanced skills training pathways with flexible curricula</p> <ul style="list-style-type: none"> ➤ Ensure training pathways are sufficiently flexible and supportive to adapt to the individual, professional, and personal context of rural doctors seeking an AST in order to meet the Collingrove Agreement Rural Generalist definition ➤ Colleges may have to review and realign existing curricula and develop new flexible curricula that can be adapted to a range of individual circumstances ➤ Work towards locally based, flexibly delivered advanced skills training pathways for rural doctors wanting to meet the Collingrove Agreement Rural Generalist definition ➤ Facilitate education and upskilling rotations for rural proceduralists between metropolitan and rural centres.
<p>Facilitate locally delivered professional development</p> <ul style="list-style-type: none"> ➤ Actively facilitate efforts to deliver training (procedural and non-procedural, simulation) onsite where doctors live and practice. Adopt the principle that, wherever possible, training and education for rural doctors is delivered in rural settings. ➤ Seek to improve access to emergency training rural doctors (e.g. Emergency Medicine Education and Training (EMET)). ➤ Serve as conduit for information on college training opportunities.
<p>Mentoring</p> <ul style="list-style-type: none"> ➤ Verify rural doctors know what mentoring opportunities their employer/sector provides ➤ Seek to identify suitably qualified rural doctors willing to be a mentor to less experienced doctors ➤ Oversee a mentoring program for rural doctors

Table 16: Key support framework considerations pertinent to Theme 3

3.4 Valuing Rural General Practice (Theme 4)

Introduction

This section introduces the results yielded from the components of the online survey and the semi-structured interviews pertinent to Guiding Principle 9: An overview of the relevant data collection sources is summarised in Table 17.

From the analysis of these findings, the primary theme **'Valuing Rural General Practice'** emerged.

This comprised of two subthemes:

- Rural GP in practice; and
- General practice viability.

The theme, subthemes and contributing factors have been summarised in Table 18.

The Viability of existing Rural General Practice is Enhanced (Principle 9)	
1. In your opinion, what does the future of rural general practice look like in Queensland?	

Table 17: Data collection source: Interview guide and principles related to Theme 4: Valuing Rural Generalist Practice

Critical to the health of people living in rural and remote communities is the reasonable access to high quality and holistic primary care services, delivered from accredited general practices, capable of meeting the diverse primary healthcare needs of those communities. The pilot project sought to explore rural doctors' ideas about the value and viability of rural practice and to learn what these doctors' thought could be done to strengthen it.

Understanding what influences the value of rural general practice may help to identify effective workforce strategies for sustaining comprehensive, cost-effective rural general practice.

Theme 4: Valuing Rural General Practice	
Guiding Principles	
Principle 9	<i>The viability of existing rural general practice is enhanced</i>
Subthemes	Contributors
<ul style="list-style-type: none"> ▪ Rural GP in Practice 	<ul style="list-style-type: none"> · Recognition and Reward · Attraction and Workforce
<ul style="list-style-type: none"> ▪ General Practice Viability 	<ul style="list-style-type: none"> · Funding Model · Business Support

Table 18: Theme 4 with subthemes and contributors

Results

Quantitative Findings

Guiding Principles

Online survey respondents were asked to rate on a scale from one to five (1 = Not at all important; 5 = Extremely important) how important each Guiding Principle is for the design and development of a Post Fellowship Support Framework. The results relevant to the theme of Valuing Rural Generalist Practice are provided below.

Guiding Principle		Mean Rating (out of 5)
• Principle 9	<i>The viability of existing rural general practice is enhanced</i>	4.57

The mean rating received for the principle was greater than four (4 = Very important). This was the **second highest** score received out of all the principles. It was clear from this result that survey respondents believed it was essential to incorporate this principle into the design and development of a Post Fellowship Support Framework.

Qualitative Findings

Rural GP in Practice

The first subtheme to emerge from analysis of data provided by respondents about Valuing Rural General Practice was 'rural GP in practice'. The responses demonstrated that more support was needed to foster success in practice. It was suggested that if capability was enhanced, rural health outcomes would also improve. The key contributors to this subtheme are discussed next.

Recognition and reward

Concern about recognition and reward in their current role was expressed by some respondents. They commented that GPs deserve far greater recognition for the service they provide to their local rural and remote communities, citing that this value was especially evident by the role they performed in supporting their communities through the disasters of 2020. Receiving this recognition would go a long way to strengthening general practice in rural communities.

Comments about remuneration focused on the need for sufficient income, not just to attract doctors but also to encourage recruits to remain in rural areas. As discussed in section 3.2, doctors who choose to work in rural and remote locations face increased expenses compared to those who do not, and this should be considered when determining remuneration for rural GPs.

"They need to do more things for private GPs in the rural [towns] and encourage private GPs because people will move out for profit but it's also lifestyle and profit." (GP_S29).

When discussing Rural Generalists and the NRGPs, most rural GPs saw being recognised as an endorsed specialist in status and in remuneration was a positive step for the profession.

In contrast, some rural hospital doctors expressed concern about the attractiveness of being a Rural Generalist if it required them to work in general practice which was perceived to provide less pay and less support than their existing roles in the hospital system. Comments included:

“The current remuneration model makes general practice unappealing to doctors of my generation. When working for the public health system I turn up, work hard, get paid well and supported with leave. The comparison with general practice is stark.” (SMO_S_p549).

A concern was also raised that the NRGPs may have a negative impact if doctors were not willing to take part in extra training to meet the Rural Generalist definition outlined in the Collingrove Agreement as this could lead to ‘two tiers’ of rural doctor remuneration where rural doctors are remunerated by state based industrial elements as Rural Generalists or under the current commonwealth funded arrangement of fee for service for rural GPs working outside the hospital system.

Attraction and workforce supply

In the context of ongoing issues of medical workforce shortages and maldistribution in rural areas, doctors commented that the perception that rural general practice was hard and required long hours of commitment was a major barrier to attracting doctors, pointing out that this was a contributing factor to the decreasing workforce pipeline and the progressive drift away from rural general practice.

“The proportion of new graduates interested in rural general practice seems to be dropping. It’s still challenging and there’s still challenges.” (VMO_GP_M2).

The immediate consequences of this were reported to be busier workloads as less doctors are available to provide care to the communities, and inability to secure reliable locums to provide additional capacity or backfill to general practices (with the pandemic-related restrictions on travel across states making an existing difficult situation even more difficult). This in turn was leading to burn-out. It was largely suggested that workforce shortages would continue to be a threat to the viability of rural general practice into the future.

“I think the workforce shortage will definitely be an ongoing issue.” (GP_VMO_M10).

Respondents observed that fewer doctors were entering general practice training as it was not seen to be an attractive option. One reason suggested for this was that becoming a GP does not appeal to the new generation’s strong preference for non-GP specialisation. Further, it was asserted that encouragement was given by hospital staff specialists for junior doctors to consider non-GP specialisation instead of a GP career during their early hospital training years.

“The Government hasn’t done much to encourage people to do general practice ... The first line of [financial] cuts always comes to general practice.” (GP_VMO_M10).

The findings also suggested that in rural and remote locations, primary and secondary sectors were in competition to attract and retain doctors. It was suggested that this did not augur well for the future of general practice with many doctors indicating that remuneration and

employment conditions offered to hospital doctors were far more attractive and conducive than those available in general practice.

“But generally, I think the main trouble I see here is often you can have problems getting staff in general practice. Mainly because quite often staff can get better working conditions and better money, and they get better benefits with Queensland Health.” (GP_H15).

General Practice viability

The second subtheme to emerge from analysis of data provided by respondents about Valuing Rural General Practice was ‘general practice viability’. Overall, the data described a level of concern for rural general practice into the future. Interestingly and in contrast, more senior rural GPs demonstrated a higher level of optimism about practice viability than the younger ones. This may have been reflective of them being in a better financial situation from having had a longer working career in their rural practices or of their ability to conduct a mixed billing practice (private fees and bulk billing) in towns where the community was less socially disadvantaged and able to pay for their medical services.

The key contributors to the subtheme of ‘general practice viability’ are discussed below.

Funding Model

Respondents commented that highly trained and skilled rural doctors provided comprehensive services to their rural community because availability of non GP specialists was reduced relative to metropolitan areas, and that the differential fee for service under the Medicare Benefits Schedule (MBS) for non GP Specialists and GP Specialists for the provision of similar services was deemed as under valuing the healthcare that was provided in rural towns.

Respondents indicated that much of their time was being spent in the complex management of chronic conditions of an ageing population. In addition, there has been a substantial increase in the prevalence of anxiety and mental health issues in these rural communities. Respondents stated that managing these complexities is inadequately funded under the current time-based fee for service, as offered in the MBS.

“Developing sustainable workforce options to improve private GP options for patients would improve their wellbeing and care. Medicare bulk-billing practices are not sustainable to adequately compensate professionals wanting to work as a private GP.” (GP_S_p558).

Analysis of the responses revealed that rural doctors felt they needed better remuneration for their work and that funding reform was needed to ensure Medicare rebates matched the value and the types of services provided by rural GPs.

“Medicare rebate is just not adequate at all ... it’s just not worth my while financially to do it [working in general practice].” (VMO_GP_M2).

Business Support

Several factors that inhibit optimal business and practice operations were reported. Responses indicated that there was inadequate business and practice operations support initiatives provided to GPs, especially younger doctors embarking in private practice. In addition, available business support lacked rural specificity.

The inadequate patient rebates in the MBS as outlined above, compounded by the recent MBS indexation freeze, as well as the high overhead professional costs associated with practising as a GP (staff wages, telecommunications, IT requirements, power and the necessary medical equipment and supplies) were not surprisingly mentioned as further deterrents.

Several comments were provided by the participants regarding how GPs and their practices aren't always set up to know how to access all the practice incentive and workforce incentive payments available to them, demonstrating a need for further education and support in business and practice support. This could also be due to the fact that there is a dearth of up to date practice management skills in rural areas where practices largely operate as small cottage businesses with limited staffing.

There is a need to mentor general practice managers on the aspects of running a successful business. As one doctor said:

"Let's face it, private practice is private practice, and it's a business, with accounting, insurances, lease agreements and a lot of terrifying stuff in there. We need to be able to mentor someone through it, so they don't have a nervous breakdown."(MS_F24).

Discussion

The fourth theme to emerge from the findings was Valuing Rural General Practice. In general, the data collected during the pilot project did not offer a favourable outlook for the future of general practice in rural areas. Whilst it is acknowledged that the results may have been impacted by the timing of the project – which was during the COVID-19 pandemic – the data was still considered to have achieved a valuable insight into the current experiences and attitudes related to Valuing Rural General Practice.

Responses related to the importance for informing a Post Fellowship Support Framework, Guiding Principle 9 '*The viability of existing rural general practice is enhanced*' rated second highest out of all the guiding principles with only Guiding Principle 3 '*Job satisfaction is a critical element in working in rural and remote areas*' rating higher. Therefore, it is critical that the Post Fellowship Support Framework incorporates enablers to enhance general practice viability in its design to attract and retain doctors in rural and remote areas.

Analysis of the findings related to Valuing Rural General Practice were arranged in two subthemes, each of which identified contributory elements that enabled or inhibited successfully valuing rural general practice.

The first subtheme, *rural GP in practice*, described the key factors impacting rural practice right now.

The findings revealed that both remuneration and workforce supply (impacted by the ability to attract doctors to the GP profession) were significantly impacting rural general practices. General practice was seen to be competing with non-GP specialty areas and the secondary healthcare sector for eligible recruits for training. Winning the battle was being impaired by the attraction to completing a recognised non-GP medical specialty and the attractive remuneration offered to hospital doctors by Queensland Health.

The effect of this was a medical workforce that was faced with complex caseloads, without easy access to doctors available to provide additional capacity or to provide relief cover, leading to

burn-out for GPs and a perception that rural general practice was less attractive than other employment opportunities. Urgently addressing these challenges was advised by respondents, acknowledging that to do so will require commitment from all relevant stakeholders and funders.

A suggested strategy is to proactively promote rural general practice as an attractive career and to encourage training doctors who display abilities and attributes well-suited to general practice to consider this option.

A suggested strategy is to leverage the Support Framework to develop workforce models that improve professional, workload and training capacity for all rural doctors in both private and public sectors, focussing investment on community outcomes.

The second subtheme, *general practice viability*, demonstrated that doctors generally held a pessimistic view of how viable general practice is and that more needs to be done to support general practices in rural and remote locations.

The findings showed it was widely felt that the fee-for-service payment system on which the general practice funding model operates is not capable of sustaining general practice in rural and remote locations now or into the future, where there are challenges in running a full fee business model when communities expect or require bulk billing models of primary care. Practice business viability is significantly compromised where bulk billed fee structures are solely relied on; as revenue is unlikely to meet business costs. It was repeatedly stated that MBS rebates undervalued the diversity of services provided by a GP and were insufficient for viable practice in a rural and remote location.

The outlook for rural general practice viability was reported as uncertain with some expressions of more or less positivity given, conditional on support to effect the necessary changes to strengthen general practice. Responses may have been impacted by the current pandemic during which fewer patients have presented to their local general practice, limiting revenue further. The temporary introduction of telehealth items for GPs until 31 March 2021, are yet to demonstrate their intended ability to alleviate the financial impact of the current practice viability crisis for general practices.

The findings demonstrated training and support was needed to ensure general practices were operating effectively as small businesses. It was noted that a need existed for providing the practice management knowledge and capability necessary to structure the businesses appropriately so that appropriate practice incentives were received. A need for rural-specific general practice business and operational support, including business mentoring was identified as a function of a Coordination Unit.

A suggested strategy is to ensure general practices receive the practice management and business support training they require to function at their full potential.

Another suggested strategy is the ability to train practice managers on all aspects of GP business operations.

Findings related to how a Post Fellowship Support Framework could positively impact Supporting Training and Education and the components that doctors said should influence the design and development of the framework are displayed in Table 19.

Theme 4: Valuing Rural General Practice
 Considerations for the Post Fellowship Support Framework

Reward and recognition

- Investigate and facilitate the provision of services at their local hospital by GPs who meet the NRGP endpoint by encouraging their engagement as VMOs or by partaking in on-call arrangements, to supplement their incomes from rural general practice and benefit from industrially agreed state incentives
- Brand and market the NRGP to increase awareness of the initiative and promote interest.

Workforce supply

- Assist doctors to source available doctors suitably qualified to cover periods of leave
- Work with rural workforce stakeholders to identify strategies to foster reliable supply of relief doctors who possess the skills necessary to provide rural medical services
- Work with rural workforce stakeholders to promote rural practice as an attractive option.

Business mentoring and support

- Ensure training is available to teach or mentor skills required for operating a business (general practice) in a rural and remote location
- Assist rural practice managers and reception staff in setting up a collegiate forum to share experiences and foster learning
- Develop a blueprint for succession planning to ensure the knowledge and infrastructure of the business is secured.

Table 19: Key support framework considerations pertinent to Theme 4

4.0 Conclusion and Future Direction

The pilot project discussed four themes which reflect key areas of support that rural doctors identified must be provided to assist doctors who have achieved Fellowship and wish to practice according to the Collingrove Agreement definition of Rural Generalist to reach the NRGF endpoint. Key support considerations for each area were outlined in section 3. The findings from the pilot project are considered 'building blocks' with which the Post Fellowship Support Framework will be designed and developed. As Queensland has a Rural Generalist Pathway that aligns well to the National model, there is opportunity to leverage the implementation of the National Pathway into Queensland in order to:

- support existing rural doctors in both primary and secondary care sectors to adopt the necessary skills and operating models that align to the Rural Generalist definition, enabling those who wish to attain National recognition as a Rural Generalist to do so
- evaluate and build the necessary coordination that delivers a highly skilled integrated medical workforce career beyond Fellowship that adjusts to emerging community change and need into the decades ahead.

The design and development of the Post Fellowship Support Framework is outside the scope of this pilot project and will be progressed through the next phase. The purpose of this section therefore is to outline how the building blocks from the pilot project (phase one) should inform the construction of the full-scale Post Fellowship Support Framework (phase two).

The Post Fellowship Support Framework will be aligned to a Rural Generalist Workforce **Vision Statement** adopted by QCP. The vision statement is:

*For Rural Generalists to be recognised, valued and provided with opportunities for tailored upskilling and maintenance of additional skills and to coordinate **all** opportunities for a fulfilling career in an integrated health system that shares resources to sustainably meet local community need.*

Pillars that reflect the four key support areas identified during the pilot project will underpin the Post Fellowship Support Framework. The **four Pillars** are:

- **Pillar 1:** Connecting Primary and Secondary Care
- **Pillar 2:** Valuing a Rural Career
- **Pillar 3:** Supporting Training and Education
- **Pillar 4:** Valuing Rural General Practice

The findings from the pilot project have identified important priorities and challenges raised by rural doctors themselves. The important next steps will involve engagement and consultation with the broader rural stakeholder group to discuss and agree on the coordination unit support functions and confirm responsibility for these functions.

It will be necessary to go beyond joined up training concepts and commit to joined up practice domains that deliver integrated sustainable access to medical care for rural communities by supporting the workforce that provides the care, placing the local model of care at the forefront of

future considerations and investing in innovative design for support elements that enhances Rural Generalist careers.

The implementation of the National Rural Generalist Pathway into Queensland will require adaptation of elements of the existing Pathway. However, the greatest opportunity is for the implementation of NRGP and expand the coordination function beyond training and into the next phase of coordinating rural generalist workforce models and support elements that attract, retain and sustain rural generalist practice.

References

- [1] National Rural Generalist Taskforce – National Rural Generalist Pathway, Australian Government – National Rural Health Commissioner, December 2018
- [2] Worley, P. S., O'Sullivan, B., & Ellis, R. (2019). From locum-led outposts to locally led continuous rural training networks: The National Rural Generalist Pathway. *Med J Aust*, 211(2), 57-59 e51. doi:10.5694/mja2.50225
- [3] Sen Gupta, T.K., Manahan D.L., Lennox, D.R., Taylor, N.T. The Queensland Health Rural Generalist Pathway: providing a medical workforce for the bush. *Rural Remote Health* (internet) 2013:13:2319
- [4] Schyve P. Leadership in healthcare organizations: a guide to joint commission leadership standards. The Governance Institute. 2009. Accessed online: www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf
- [5] Phillips N (2010) Leadership. In Kaufman G, McCaughan D (2013) The effect of organisational culture on patient safety. *Nursing Standard*. 27, 43, 50-56.
- [6] Sharma M. (2017) Radical Transformational Leadership: Strategic Action for Change Agents. Berkeley, CA: North Atlantic Books. In Huston, C (2018) What defines a true leader in healthcare? *Today's Wound Clinic*. Vol 12, Issue 9.
- [7] Queensland Clinical Senate – connecting clinicians to improve care Meeting Report – Published by the State of Queensland (Queensland Health, October 2015)
https://www.health.qld.gov.au/data/assets/pdf_file/0024/442635/qcs-meeting-report-201510.pdf
- [8] [Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.](#)
- [9] Russell DJ, McGrail MR. How does the workload and work activities of procedural GPs compare to non-procedural GPs? *Aust J Rural Health*. 2017 Aug;25(4):219-226. doi: 10.1111/ajr.12321. Epub 2016 Sep 7. PMID: 27600557.
- [10] Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In W. Stainton Rogers, & C. Willig (Eds.), *The SAGE Handbook of Qualitative Research in Psychology*, (17-37).(2nd). London: SAGE Publications
- [11] Glazebrook RM, Harrison SL. Obstacles and solutions to maintenance of advanced procedural skills for rural and remote medical practitioners in Australia. *Rural Remote Health*. 2006 Oct-Dec;6(4):502. Epub 2006 Nov 15. PMID: 17107272.
- [12] McKenzie A, Beaton N, Hollins J, Jukka C, Hollins A. Supporting GP advanced rural skills training. *Aust J Rural Health*. 2013 Feb;21(1):41-5. doi: 10.1111/j.1440-1584.2012.01315.x. PMID: 23384136.
- [13] Alexander C, Fraser J, Retaining Australian trained doctors and International Medical Graduates in rural Australia: A case of special professional needs? Paper to 7th International Conference on Rural Health WONCA, Seattle, USA, 8-10 September 2006.

- [14] Alexander, C., & Fraser, J. (2007). Education, training and support needs of Australian trained doctors and international medical graduates in rural Australia: a case of special needs? *Rural and remote health*, 7 2, 681.
- [15] World Health Organization (2010) "Increasing access to health workers in remote and rural areas through improved retention global policy recommendations", WHO Press, World Health Organization, Switzerland
- [16] Australian College of Rural and Remote Medicine. "Barriers to the maintenance of procedural skills in rural and remote medicine". Brisbane, QLD: Australian college of Rural and Remote Medicine Research Project, 2002
- [17] Morley, L., & Cashell, A. (2017). Collaboration in Health Care. *J Med Imaging Radiat Sci*, 48(2), 207-216. doi:10.1016/j.jmir.2017.02.07
- [18] Australian Association of Practice Management (AAPM) Position Paper 2018
- [19] Mitchell Geoffrey K., BurrIDGE Letitia, Zhang Jianzhen, Donald Maria, Scott Ian A., Dart Jared, Jackson Claire L. (2015) Systematic review of integrated models of health care delivered at the primary-secondary interface: how effective is it and what determines effectiveness? *Australian Journal of Primary Health* 21, 391-408.
- [20] Trankle, S.A., Usherwood, T., Abbott, P. et al. Integrating health care in Australia: a qualitative evaluation. *BMC Health Serv Res* 19, 954 (2019). <https://doi.org/10.1186/s12913-019-4780-z>
- [21] Mann, R., Ball, K., & Watson, G. (2011). Mentoring for NHS general practitioners: a prospective pilot study of an action learning approach. *Educ Prim Care*, 22(4), 235-240. doi:10.1080/14739879.2011.11494006
- [22] de Moore, G., Smith, K., & Earle, M. (2006). From golden beaches to the heartland: reflections of NSW rural trainees. *Australas Psychiatry*, 14(1), 72-75. doi:10.1080/j.1440-1665.2006.02249.x
- [23] Henry, J. A., Edwards, B. J., & Crotty, B. (2009). Why do medical graduates choose rural careers? *Rural Remote Health*, 9(1), 1083.
- [24] Kwan, M. M. S., Kondalsamy-Chennakesavan, S., Ranmuthugala, G., Toombs, M. R., & Nicholson, G. C. (2017). The rural pipeline to longer-term rural practice: GPs and specialists. *PLoS One*, 12(7), e0180394. doi:10.1371/journal.pone.0180394
- [25] Stagg, P., Greenhill, J., & Worley, P. S. (2009). A new model to understand the career choice and practice location decisions of medical graduates. *Rural Remote Health*, 9(4), 1245.
- [26] Pathman DE, Konrad TR, Williams ES, et al. Physician job satisfaction, dissatisfaction, and turnover. *J Fam Pract* 2002; 51: 593.
- [27] Ulmer B, Harris M. Australian GPs are satisfied with their job: even more so in rural areas. *Fam Pract* 2002; 19: 300-303.
- [28] Benson J, Magraith K. Compassion fatigue and burnout: the role of Balint groups. *Aust Fam Physician* 2005; 34: 497-498.
- [29] McLean R. Continuing professional development for rural physicians: an oxymoron or just non-existent? *Intern Med J* 2006; 36: 661-664.
- [30] Wainer J. Sustainable rural practice: successful strategies from male and female rural doctors. Traralgon, Vic: Monash University School of Rural Health, 2004.

- [31] Strasser R, Lanphear J. The Northern Ontario School of Medicine: responding to the needs of the people and communities in Northern Ontario. *Education for Health*, 2008, 21:3.
- [32] Janssen, M., Sagasser, M.H., Fluit, C.R.M.G. et al. Competencies to promote collaboration between primary and secondary care doctors: an integrative review. *BMC Fam Pract* 21, 179 (2020). <https://doi.org/10.1186/s12875-020-01234-6>
- [33] Mianda, S., Voce, A. Developing and evaluating clinical leadership interventions for frontline healthcare providers: a review of the literature. *BMC Health Serv Res* 18, 747 (2018). <https://doi.org/10.1186/s12913-018-3561-4>
- [34] Pastor WH, Huset RA, Lee MC. Job and life satisfaction among rural physicians. Results of a survey. *Minn Med*. 1989 Apr;72(4):215-23. PMID: 2716716.
- [35] The Royal Australian College of GPs. *General Practice: Health of the Nation 2019*. East Melbourne, Vic: RACGP, 2019.
- [36] Department of Health, Government of Western Australia, WA Country Health Service, *Engaging Rural Doctors, Final Report, 2007*
- [37] Le Floch, B., Bastiaens, H., Le Reste, J.Y. et al. Which positive factors give GPs job satisfaction and make general practice a rewarding career? A European multicentric qualitative research by the European general practice research network. *BMC Fam Pract* 20, 96 (2019). <https://doi.org/10.1186/s12875-019-0985-9>
- [38] Sharkey, Jennifer & Caska, Barbara. (2020). Work-Life Balance versus Work-Life Merge: a Comparative and Thematic Analysis of Workplace Well-Being. *DBS Business Review*. 3. 10.22375/dbr.v3i0.59.
- [39] La Rocca A, Hoholm T. Coordination between primary and secondary care: the role of electronic messages and economic incentives. *BMC Health Serv Res*. 2017 Feb 17;17(1):149. Doi: 10.1186/s12913-017-2096-4. PMID: 28212653; PMCID: PMC5316199.

Appendix 1: Interview Questions

Post Fellowship Support Framework

Semi-structured Interview Guide

Welcome. Declare that the interview will be recorded and seek consent for same. Introduction. Purpose.
Opening Question
1. How many years have you been a medical practitioner in a rural or remote community and how many years have you been in this town?
If more than 10 years' experience, ask the following question:
Please comment on some of the changes that you have experienced?
Principle 1: Collaboration and coordination between primary and secondary care
3. If you had to rate the collaboration between primary and secondary care in your town on a scale of 0-10, with 0 not working at all and 10 working extremely well, how would you rate it? e. Why did you give it that rating? Can you please give me a recent example? f. Would you describe what is currently working well? g. Would you also describe how collaboration could be improved? h. How could you see that happening?
4. Please rate between 0-10 (with 0 not supporting at all and 10 supporting extremely well) how well you believe support systems work to foster collaboration and coordination of care in your town. a. In your opinion, what works well? b. What can be done better or differently?
Principle 6: The ability to work across hospital and general practice facilities to provide coordinated care is supported
1. Please rate between 0-10 the current situation in your town relating to ease of access for doctors to work in both primary and secondary care settings? a. Why did you give it that rating? (probe for specific examples)
2. I would now like to ask you about your experience about working in both General Practice and hospital settings?
If interviewee is from Town B, also ask the following question:
Are you interested in working across both primary and secondary care setting?
Principle 2: Rurally based career paths are recognised and valued
Principle 3: Job satisfaction is a critical element in working in rural and remote areas
1. What are the things that have influenced your career decisions to date?
2. Rate between 0-10 how satisfied you are with your current work? (from '0 = Not at all satisfied', to '10 = Extremely satisfied') a. Why did you give it that rating? Can you give examples of both positive and areas for improvement?
3. What would keep you working as a doctor in this town?
4. What is it that makes you feel valued as a rural clinician?
5. If Queensland were to put into place a post fellowship support framework for all doctors, what do you see are some of the key elements of such a framework and how will it support you in your rural career into the future?

Principle 7: Education and training needs are supported

Principle 8: Professional peer support is available

- 1. How would you rate from 0-10 the ability for you to undertake educational activities in/from your town? (from '0 = No support', to '10 = A lot of support')**
 - a. why did you give it that rating?
- 2. How would you rate from 0-10 the support from your professional peers in your town? (from '0 = No support', to '10 = A lot of support')**
 - a. why did you give it that rating?
- 3. In your opinion, what is working or what could be done to improve educational and professional peer support in your town?**
- 4. If Queensland were to put into place a post fellowship support framework for all doctors, how might the framework enable improved educational and professional peer support?**

Principle 4: The ability to attain advanced skills is supported to meet community need

- 1. Have you completed your advanced skills training? (Yes/No)**

If 'No', also ask the following questions:

- a. have you ever considered pursuing advanced skills training?
- b. If so, what skill would that be and why?

If 'Yes', also ask the following questions:

- a. What are your advanced skills?
- b. Are you able to use your advanced skills in your current role?
- c. Can you meet the requirements for maintenance of this advanced skill?

- 2. If Queensland were to put in place a post fellowship support framework for all doctors, what would you see is its role in supporting your advanced skill or influencing you to do further skillstraining?**
- 3. If you aren't interested in advanced skills training, are you able to explain your reasons why?**

Principle 5: The ability to obtain, maintain and upgrade procedural skills in hospitals or general practice is supported to meet community needs

- 1. How do you maintain your procedural knowledge/skills?**
- 2. How can support for procedural skills in general practice and hospital settings be developed to encourage medical practitioners to obtain procedural skills that meet the needs of your community and practice?**
- 3. If Queensland were to put in place a post fellowship support framework for all doctors, what would you see is its role to encourage, obtain, maintain and upgrade your procedural skills?**

Principle 10: Clinical leadership development is recognised, enhanced, encouraged and supported

- 1. As a rural doctor, why is it important that you have good clinical leadership in your town?**
 - a. What are some examples of good leadership in your town and what could be improved?
- 2. Can you tell me about your interest in developing your own leadership skills?**
 - a. How could you be supported to do that?
 - b. If you are not interested in developing your own leadership skills, why not?
- 3. If Queensland were to put in place a post fellowship support framework for all doctors, what would you see is its role in providing opportunities for leadership development and training?**

Principle 9: The viability of existing rural general practice is enhanced

- 1. In your opinion, what does the future of rural general practice look like in Queensland?**

National Rural Generalist Pathway

The Commonwealth Government is currently moving ahead in developing a National Rural Generalist Pathway

1. Are you aware of this initiative?
2. Do you think this will impact in any way on your career pathway?

Collingrove Agreement and Rural Generalist Definition

Both GP Colleges have currently been tasked to work with the AMC and the Medical Board to obtain recognition of rural generalism as an endorsement following fellowship in general practice. The Collingrove Agreement has defined a Rural Generalist as:

“a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural health care team”

1. **Should Rural Generalism become recognised in such a way by the Medical Board of Australia:**
 - a. How would this impact you?
 - b. Would you be encouraged to undertake further training to meet this definition of Rural Generalism?
 - i. If so, what?
 - ii. If not, why?
2. **If Queensland were to put in place a Post Fellowship Support Framework for all doctors, what would you see is its role in supporting doctors who have achieved fellowship to obtaining whatever is necessary to meet this definition?**
3. **In your opinion, what else can be done to support post fellowship doctors working in rural and remote Queensland?**
4. **Is there anything else you wish to add?**

Appreciation

Thank you for taking the time to provide your valuable insight about rural medicine. Your contributions are appreciated and will be used to inform the design of a Post Fellowship Support Framework.

Appendix 2: Survey Questions

Post Fellowship Support Framework

Online Survey Questions

Thank you for agreeing to assist in this project to develop a support framework for post fellowship rural doctors in Queensland. The best way to develop a successful framework is to hear from you, the doctors currently working in rural and remote Queensland. To assist us we have developed a survey that should take less than 10 minutes to complete and your responses will be anonymous. Information gathered will be used to design a full-scale support framework as one of the building blocks of the National Rural Generalist Pathway.

Consent

Q1: Selecting 'Continue' implies your consent to participate in the survey:

- Continue
- Not now

Skip to end of survey if response = Not now

Demographics

Q2: In which town(s) do you currently work? (optional)

Q3: Approximately how many years have you been a medical practitioner in this town(s)?:

- Less than 1 year
- 1 years
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years
- 11 – 15 years
- 16 – 20 years
- 21 – 25 years
- More than 25 years

Q4: Sex:

- Male
- Female
- Unspecified

Q5: Do you hold specialist registration?

- Yes
- No
- No, but I am in training (Registrar)

Display Q6 if response = Yes

Q6: In which specialty(s) do you hold specialist registration? (e.g. General Practice; Surgery; Palliative Medicine)

Collingrove Agreement

The Collingrove Agreement defines a National Rural Generalist as a clinician who provides comprehensive care in:

- Both general practice and emergency care
and
- Other medical specialist care in a hospital and community setting

Q7: In the last 12 months have you worked in a manner consistent with the Collingrove Agreement?

- Yes
- No
- Unsure

Display Q8 and Q9 if response = No

Q8: Which part(s) of the definition do you not meet?

Q9: Which of the following best describes your current work setting(s)?

- General practice only
- Aboriginal Medical Service only
- Hospital only
- Both general practice/AMS and hospital

Display Q10 if response = General practice only OR if response = Aboriginal Medical Service only

Display Q11 if response = Hospital only

Display Q14 if response = Both general practice/AMS and hospital

Q10: Would you be interested in working in the hospital in addition to your current work setting?

- Yes
- Maybe
- No

Display Q12 if response = Yes OR if response = Maybe OR response = No

Q11: Would you be interested in working in general practice in addition to your current work setting?

- Yes
- Maybe
- No

Display Q13 if response = Yes OR if response = Maybe OR response = No

Q12: Please explain your response? (including any supports / barriers to working in both general practice and the hospital to meet your community's health needs)

Q13: Please explain your response? (including any supports / barriers to working in both general practice and the hospital to meet your community's health needs)

Q14: Your last response indicates that you are working in both general practice and the hospital (if not, use the back arrow to return to the previous question).

Please describe what works well and/or what could be improved to foster collaboration and coordination between the two settings?

Principles to guide the Post Fellowship Support Framework

Please rate how important you believe the following principles are for post fellowship doctors working in rural and remote communities:

Q15: Principle 1: Collaboration and coordination between primary and secondary care is vital.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				

Q16: Principle 2: Rurally based career paths are valued.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				

Q17: Principle 3: Job satisfaction is a critical element in working in rural and remote areas.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				

Q18: Principle 4: The ability to attain <i>advanced skills</i> is supported to meet community need.					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q19: Principle 5: The ability to obtain, maintain and upgrade <i>procedural skills</i> in hospitals or general practice is supported to meet community needs					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q20: Principle 6: The ability to work <i>across hospital and general practice</i> facilities to provide coordinated care is supported					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q21: Principle 7: <i>Education and training</i> needs are supported.					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q22: Principle 8: Professional <i>peer support</i> is available.					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q23: Principle 9: The <i>viability</i> of existing rural general practice is enhanced.					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q24: Principle 10: <i>Clinical leadership</i> development is supported.					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Importance Rating	<input type="radio"/>				
Q25: Please provide any <i>further comments</i> relating to the principles mentioned above.					
<hr/> <hr/> <hr/> <hr/>					

National Rural Generalist Pathway

Q26: Will the introduction of a National Pathway *impact* your current work?

- Yes
- No
- Unsure

Q27: Please *explain* your response?

Final comments

Q28: Please outline any other aspects *not covered* in the survey that should be considered in the development of a support framework to help post fellowship rural doctors to meet the health care needs of their community?

Appreciation

Thank you for providing your views. We appreciate the time you have taken and will actively use this information to inform the design of a full-scale Post Fellowship Support Framework.

Appendix 3: Stakeholder Engagement

Rural Medicine Stakeholder Engagement Forum

Invitee List for sharing Preliminary Results

Key rural medicine stakeholders were invited to attend an information forum in December 2020. This forum provided an opportunity to present early findings from the pilot project.

Agency
Health Workforce Queensland (HWQ)
Royal Australian College of General Practitioners (RACGP)
Australian College of Rural and Remote Medicine (ACRRM)
Rural and Remote Clinical Network
Rural Doctors Association of Queensland (RDAQ)
James Cook University (JCU)
Queensland Rural Generalist Program
General Practice Training Queensland (GPTQ)
Office of Rural and Remote Health
Queensland Country Practice
Queensland Rural Medical Service

Appendix 4 A: Online Survey Results

10 Guiding Principles

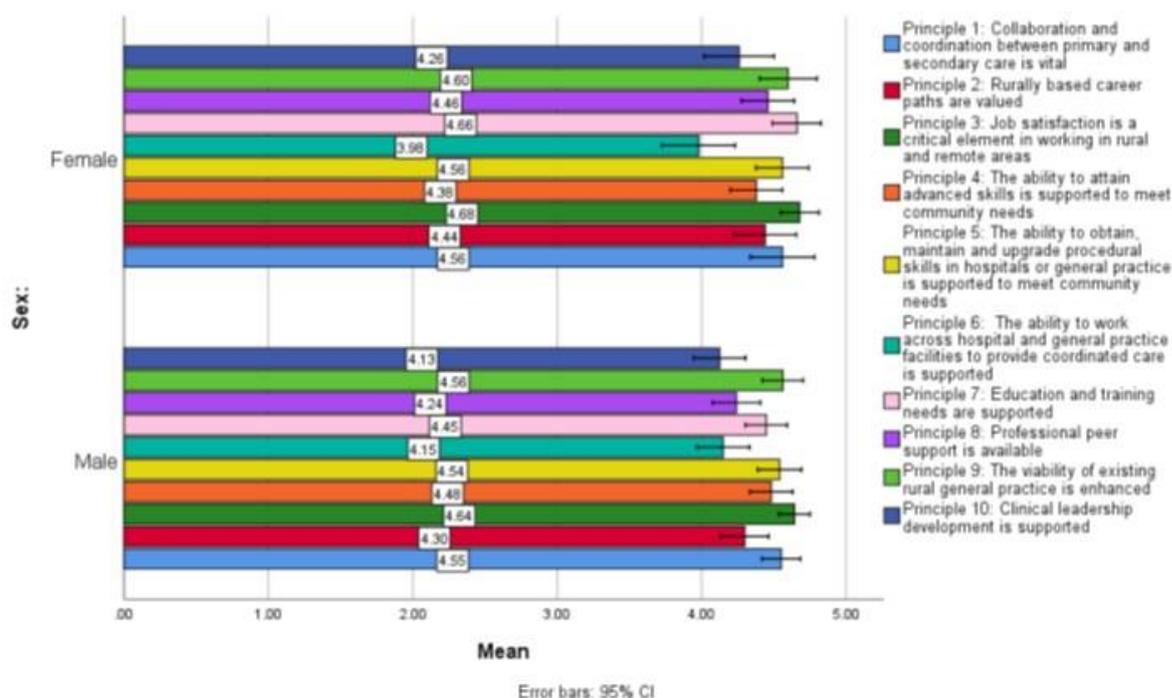
Importance Ratings: By respondent category

Respondents were asked to provide an importance rate to each of the 10 Guiding Principles using a Likert-type scale (1 = Not at all important; 5 = Extremely important). Mean ratings for the principles are displayed below.

Overall ratings:



Ratings by respondent category: Sex



Ratings by respondent category: Registration type

	Specialist		Registrar		General	
	M	SD	M	SD	M	SD
Principle 1	4.51	0.67	4.65	0.56	4.30	1.25
Principle 2	4.38	0.75	4.24	0.83	4.40	0.84
Principle 3	4.63	0.52	4.64	0.49	4.80	0.42
Principle 4	4.41	0.67	4.44	0.65	4.70	0.67
Principle 5	4.53	0.71	4.56	0.58	4.60	0.70
Principle 6	4.07	0.89	4.20	0.71	4.00	1.05
Principle 7	4.47	0.70	4.72	0.46	4.70	0.48
Principle 8	4.29	0.76	4.36	0.64	4.60	0.70
Principle 9	4.55	0.70	4.60	0.65	4.90	0.32
Principle 10	4.13	0.86	4.28	0.79	4.50	0.71

Ratings by respondent category: Workplace setting

	General practice only		Hospital only		Aboriginal Medical Service only		Both general practice & hospital	
	M	SD	M	SD	M	SD	M	SD
Principle 1	4.41	0.83	4.28	0.74	5.00	0.00	4.67	0.54
Principle 2	4.20	0.90	4.40	0.65	4.13	0.83	4.50	0.66
Principle 3	4.71	0.50	4.60	0.50	4.50	0.53	4.63	0.52
Principle 4	4.58	0.67	4.32	0.69	4.50	0.76	4.36	0.64
Principle 5	4.56	0.71	4.64	0.57	4.38	0.74	4.51	0.71
Principle 6	4.10	0.85	3.56	0.96	3.63	0.74	4.36	0.74
Principle 7	4.59	0.64	4.40	0.76	4.75	0.46	4.51	0.63
Principle 8	4.39	0.73	4.24	0.78	4.38	0.74	4.29	0.73
Principle 9	4.69	0.55	4.28	0.98	4.63	0.52	4.61	0.59
Principle 10	4.18	0.85	4.12	0.88	4.63	0.52	4.16	0.85

Appendix 4 B: Online Survey Results

10 Guiding Principles

Importance Ratings: Free text responses

Respondents were invited to provide any additional comments about the principles and the importance ratings. Comments have been grouped according to four common themes.

Skills, education and peer support

- *Enhancing the viability of existing rural general practice is critical. There's no point focusing only on hospital-based services at the expense of existing general practice as it will result in a relative paucity of primary care (GP) and in doing so increase the demand for secondary care (ED/hospital). The lack of **access to paid education for general practitioners** is a gaping gap in current funding. Most GPs are self-employed and as such we take a financial loss every time we take time off for further education. This is a strong disincentive to up-skill further and needs to be addressed.*
- *The educational needs of rural practitioners need to be provided. Rotational Upskilling needs to be core business, supported and funded not left to the doctor. GPs should be appropriately remunerated in line with Non-GP specialist metro peers. We need to also think about exit pathways. A generalist is rarely a rural generalist first life. At the moment the rural generalist career is a dead end. Once you decide to move back to the city you have to start at the beginning of specialist training pathways. We need **coordinated reticulated training pathways** which acknowledge and reward the rural generalist experience should they choose to return for family needs. Rather than treating an experienced DRANZCOG as a basic trainee or a GP endoscopist as a [n] entry Med reg.*
- *Individual learning and career planning would be very welcome, rural generalists live with the short comings of our health system, and they are uniquely able to develop insights to **creatively respond** to these gaps, they might be **deliberately nurtured**.*
- *Peer support and education and training support are extremely important in the early years of clinical practice (5-10 years). Then once relationships have been built, the maintenance of these relationships becomes important.*
- *I believe lots of those things are important however, **lots of them are not met in real life**. Support and teaching are terrible where I work.*
- *Further **collaboration with tertiary subspecialty teams** to allow the rural generalist to acquire and maintain essential skills for acute rural medical practice such as - echocardiography, management of severe trauma, anaesthetic crisis.*
- *In any given situation, that must be considered that regional and rural doctors and GPs have a critical role in promoting health in their communities with minimum available facilities. Having said that, it must always be a priority in any programme to consider their needs in regard to education and **allocation of more diagnostic facilities** to these areas.*
- *Well supported training for rural GP's to **maintain our skills** and knowledge for emergency and procedure is vital to serve the community.*
- ***Professional peer support** v lacking in private general practice.*
- *It's quite disappointing that professional development in the areas of **management and leadership** aren't funded by HWQ.*
- *I believe **yearly upskilling**, especially for those with procedural advanced skills is most important to ensure patient safety.*
- *These points are vitally important however the **support and value** of them by many of the specialist colleagues in hospital and private practice is **variable and sometimes totally lacking**.*

Interface of general practice and hospital

- *It is currently very hard to have significant roles as a hospital procedural doctor in Qld and still work in General Practice. Mandatory training requirements and Queensland Health **credentialing requirements are almost prohibitively demanding** for one person to have both roles.*
- *Lack of support to balance the work between the hospital and GP work is killing us. Running a GP practice to support the hospital is a headache. **Financially it is not viable** and add to never ending management role which is poorly supported.*
- *Part of the challenge is to get state (acute) and federal (primary health) funding and support for RG **employment models** - given the very definition of rural generalism spans the two domains. QH might not allow/provide primary health care (therefore only acute in the JD), nor consider employing a GP to provide any acute services - even in a p/t, casual employment. So, RGs might, due to the 'politics' be prevented from working as an RG.*
- *The existing rural general practices need to be supported. **Running small practices** with 1/2/3 doctors in small rural towns **is often challenging and financially not viable**. They need extra support from local HHS / hospitals. Some HHS have a perception that general practices are private entities and they don't support them adequately and in the long run these entities will fail.*
- *Support for primary care providers to deliver the bulk of care in community outside of hospitals to manage chronic disease is wanting. **Chronic disease management** is a core skill of FACRRM and FRACGP and there is opportunity to do this much better. Advanced skills working in general practice / AMSs such as mental health, int medicine, Paeds are too **often the poor cousin of hospital ASTs**.*
- *Hospitals have very tight funding for FTE in terms of doctors, while there are fantastic doctors without advanced procedural skills that cannot be on the on-call roster for those skills which is one of the draining/burnout factors for the other doctors. In order to attract future doctors to rural areas, a **good work environment with peer support and clinical leadership is needed**. It's also important for the private GP to know what the hospital can and cannot perform. There have been many times of double handling of patient's care unnecessarily.*
- *The **hours worked and the spread of competencies needed** is vast and I don't think it's supported enough otherwise there wouldn't be the ongoing shortages.*

Encourage sustainable rural practice

- *Developing **sustainable workforce** options to improve private GP options for patients would improve their wellbeing and care. Medicare bulk-billing practices are not sustainable to adequately compensate professionals wanting to work as a private GP.*
- *"Drs need to feel capable, confident, supported, appreciated, and in a viable system/practice. Making a difference in the community, being accepted and integrated, having family social opportunities, having sufficient access to "backfill" while away on leave or training etc are all essential for doctors to be effective rural generalists..."*
- *Encourage rural practitioners to **promote rural medicine as a career of choice** in rural schools. Support from rural colleges is needed.*
- *Work life balance is taking an increasingly important role for developing workforce. **Fractional appointments and [meeting] doctor specific interest ... seem high on all our staffs' priority lists**.*
- *Job satisfaction is paramount. And providing for upskilling/CPD to keep our communities safe. And allowing for **opportunities for part time or flexible work arrangements** to prevent burnout and increase workforce sustainability.*

Other comments

- *Support for families and children needs to be an extremely important factor and excellent financial rewards as well.*
- *The need for doctors to have an advanced skill is dependent on the size of the town and the number of doctors who service it. Too many MO's with advanced skills in a medium sized town means that maintenance of skills is not achievable.*
- *You appear to have deliberately neglected to mention remuneration. This is easily the most important factor in working rural and remote. Increased cost of living, ability to attend courses, paying for locums. It is pretty poor to not recognise the importance of remuneration.*
- *I believe all these principles are essential - and currently lacking.*

Appendix 5: Online Survey Results

Interest in working across primary and secondary services

Responses from doctors working only in a General Practice or an Aboriginal Medical Service (AMS)

Doctors currently working only in a general practice or AMS work setting were asked to select Yes, No or Unsure to the question 'Would you be interested in working in the hospital in addition to your current work setting?' and were then invited to comment on the response they selected. The free text comments provided are summarised here.

Little or no interest in also working in the hospital setting

Some comments suggested little or no interest in working in the hospital setting including comments about patient relationships, work/life balance and travel to the nearest hospital:

- *I am more interested to work as General Practitioner as in this position I have more opportunity and time with people in the community and that helps me to understand their needs better.*
- *I currently work only three full days per week. Thus, I'd find it difficult to meet my responsibilities to patients I'm treating in general practice as well as work at a hospital. If I worked full time hours, I would enjoy the variety of working in a hospital as well as general practice.*
- *I'm 70 yrs old and find call work increasingly onerous from a fatigue point of view.*
- *Not interested in hospital work at this stage of my career, I have done many yrs in hospital setting.*
- *I live 40 km from towns [with] hospitals, not keen to drive 40 minutes each way to work at this stage of my life. Current GP practice very busy, does not have enough appointments, would not be good for the practice to decrease hours to work somewhere else.*

Others mentioned the time required when working fulltime in a general practice made adding further work difficult:

- *Currently working full time at General Practice. Always fully booked out.*
- *Fulltime rural general practice is already a fulltime commitment. We provide continuity of care to our patients by providing an after-hours service, nursing home care and palliative care in the home when circumstances permit. There is simply not enough hours in my week to add emergency care and hospital care. I have done that for many years and it is not sustainable. If this is the only definition of a rural generalist you will lose many valuable rural GPs.*
- *My general practice is extremely busy and already occupies 50+ hours per week plus on call. Taking on further work (e.g. ED) would necessitate a reduction in GP hours which is likely untenable.*

Other comments reflected local hospitals being unwelcoming of GPs:

- *Local public hospital not receptive to private GPs doing ED or seasonal work.*
- *Nearing retirement. The hospital does not want GPs.*
- *I faced lots of indirect discrimination and bullying from senior nurses in the hospital, I wouldn't want to go back in the hospital setting which is full of politics especially emergency departments. That was the reason I left hospital and came into General Practice.*

One comment indicated that previous work in both settings had become burdensome:

- *I did that for 30 years and Qld Health / Hosp management have worn me down.*

Strong interest in also working in the hospital setting

Some comments were generally positive about working across general practice and the hospital:

- *I have always been interested to work in both general practice and hospital as both have their different clinical approach to patient's care. General practice provides more of preventative medicine while hospital offers emergency services.*
- *I have always had an interest in hospital and emergency work.*
- *Have always enjoyed hospital work.*
- *I would be interested in this type of work once I've completed my fellowship training, as currently trying to learn about General Practice as possible and complete by training examination and assessments.*
- *I would like myself to be credentialed for surgical work as I have vast experience in surgical procedures. This way, I will be able to cut down waiting time for my patients and decrease burden on hospital system. Also, it will benefit my patient by Improving QoL.*
- *I would like to have right to admission in our local Hospital.*
- *I wouldn't mind working in a hospital setting as I feel it would be interesting and help reduce the 5-day burnout associated with office based general practice work. However, I would worry about (1) Pay levels (2) Level of responsibility. The level of responsibility is a particularly troublesome thing in rural communities as I feel being the most senior, I would be expected to deal with situations in which I have no training (i.e. advanced obstetrics, anaesthetics).*

Barriers to also working in the hospital setting

Credentialing, skill acquisition and maintenance

Some respondents raised issues around gaining access to hospitals. For instance:

- *Credentialing with Queensland health.*
- *Currently Queensland health do not support or encourage GPs to work in their hospitals. I have admitting rights to Proserpine hospital but over the 5 years that I have been here we have been increasingly discouraged from admitting and caring for private patients. I would also be willing to undertake some VMO work if that was offered.*
- *The local hospital became so well staffed I was only working 1 weekend in 3 months and felt I was deskilled as per the QH protocols [not the ED skills] so resigned.*
- *Time, training, ability to maintain skills required for emergency department.*
- *I would like to upskill in emergency as I see many acute presentations in remote GP work.*
- *I would need to upskill in Emergency Care, would also need to ensure no shift work.*
- *I would like to upskill in emergency as I see many acute presentations in remote GP work.*
- *I would need to upskill in Emergency Care, would also need to ensure no shift work.*
- *Currently hold VMO appointment at local hospital but change in definition of "unsupervised practice" for purposes of Rural GP Procedural Grant has affected maintenance of skills.*
- *Since I have not been involved in providing Emergency Care I feel quite out of my depth if I am presented with an emergency situation.*
- *Training and hours.*

Priority of general practice over hospital work

Some comments highlighted the need to acknowledge workforce issues, work hours and settings, including general practice workload as a barrier to facilitate hospital practice:

- *Hospital work not to clash with GP work - Needs to be acceptable work hours and conditions.*
- *Rural General Practice is already extremely busy and demanding. If I can get doctors who are interested in working in my practice, I will be interested in doing anaesthetic in a rural hospital setting.*
- *Would want to work part time in both. Workload currently in general practice does not allow it and no part time positions available in hospital as far as I am aware. Cannot accommodate extra on call time in ED.*

Other

Individual comments covered a wide variety of issues including hospital administration requirements, tiredness, and the difficulty of after-hours work. For instance:

- *Long hours. Prefer to focus on good rural general practice care in AMS.*
- *Not wanting to part of an afterhours and weekend roster. Don't feel skilled in providing competent emergency/hospital treatment.*
- *Poor hospital support system, not enough training facilities.*

Appendix 6: Online Survey Results

Interest in working across primary and secondary services

Responses from doctors working only in a Hospital setting

Doctors currently working in a hospital work setting were asked to select Yes, No or Unsure to the question 'Would you be interested in working in the hospital in addition to your current work setting?' and were then invited to comment on the response they selected. Free text comments are provided here.

Little or no interest in also working in the general practice setting

Three comments indicated a clear inclination to practice in hospitals only:

- *I have worked in general practice for 20 years and do not want to go back.*
- *I prefer Hospital procedural practice but can imagine I might do more general practice in the future.*
- *I worked in both private general practice and the hospital setting for several years post fellowship. I stopped general practice last year as I found working part-time made patient follow-up at the clinic difficult.*

Strong interest in also working in the general practice setting

One respondent expressed the interest to pursue general practice:

- *I am Med Super at [XXX] Hospital and currently have limited time to spend in general practice. I do still intend to extend my current role into working in General Practice again.*

Barriers to also working in the general practice setting

Demands of hospital work

A few respondents commented on difficulties to work across general practice due to hospital demands and workload.

- *Main issue to working both in a hospital and general practice setting is mainly the on call associated with the hospital especially when working in obstetrics. There would be many times that you would have to cancel patients In GP when you are fatigued and would affect rapport and continuity of care. I do know of doctors that would push through the fatigue, but they are much more likely to burn out.*
- *It would depend on the role and the incentives. Working in General Practice and losing income or having to work more / additional hours would not be of my interest as I am working 100 hrs per FN on average already.*
- *Working full time in hospital.*
- *Balance of work life and on call commitments.*
- *Given demands of current hospital role, it would not be possible to work in general practice to an extent that would provide meaningful patient care. To do a half day a week in general practice to tick a box would not be helpful to patients. Establishing some sort of general practice clinics within the hospital setting again would be unlikely to provide quality general practice care to patients.*
- *Full time hospital.*

Remuneration and access to resources

Individuals provided comments that addressed the subject of poor remuneration in general practice, as well as the need for effective utilisation of available skills, access to training and unified IT systems.

- *Being a rural generalist is really about using a diverse set of skills to meet community need. The pathway needs to acknowledge that this encompasses more than general practice vs hospital. Ultimately, I have diverse interests and skills which I use to better rural health care. I hold educational and governance roles, as well as hospital and AST appointments. These needs are just as acute as office general practice. Also, the current remuneration model makes general practice unappealing to doctors of my generation. When working for the public health system I turn up, work hard, get paid well and supported with leave. The comparison with general practice is stark.*
- *Believe that working in General Practice is a core component of practice. However, there is a limitation of working across multiple modalities of service - General Practice, Emergency Care, Secondary Care, Advanced Practice (Obstetrics) and Medical Management with push-pull factors of multiple skill areas. It is somewhat insulting as well to consider the fact that providing good quality primary care cannot be done aligned with a rural hospital emergency department. It might be more recognised if there is alignment with IT resources such as BestPractice or Medical Director to fit in with local practices for patients presenting after hours and on weekends - when NO General Practices provide this cover. To date, QH has not supported interoperability of IT Patient Information services with General Practice. It may be improving with iMR, however currently limited support. Another difficult factor to undertake part-time GP with Hospital work is the inability to generate a patient list to adequately remunerate comparably with QH work. This is a key factor for federal remuneration opportunities aligned with the development of the NRGp.*
- *Poor remuneration in general practice with high professional costs.*
- *Would consider General Practice if paid by the hospital as part of FTE.*
- *The model of care created by the fee per service arrangement in office based general practice creates difficulties in delivering care to the places where it is most needed. The bulk of office-based GP work is an attempt at chronic disease control and secondary prevention which has a very low return on investment and would be better provided through wider based multidisciplinary programs. I prefer acute medicine.*

Workforce shortages

Some comments expressed an inability to manage workload due to workforce shortages.

- *Our community does not have sufficient general practitioners or hospital staff to manage the community workload. Already I perform a significant amount of overtime simply working in the hospital. I believe a whole of community view need to be taken to meet community needs which is difficult to coordinate with private and public aspects of each. I would be very happy to work in general practice if other qualified rural generalists were available to work on the hospital roster.*
- *Currently working 1d per week in GP. Short staffed for obstetrics in our town and difficult to facilitate on call cover with GP.*
- *Barrier to working in the community currently is extreme shortage of medical staffing at our hospital so I am unable to take time to also work in the community. We are not funded for more medical staff despite the overwhelming need - unsafe number of patients being seen, often working fatigued.*

Other comments

Additional comments provided spoke to the benefits of working as a hospital doctor, and safety issues faced by women in general practice.

- *I currently work in ED/procedural obstetrics/ward medicine and as a GP in hospital-based outpatient clinics that cater to those in our community who can't access private-billing GPs. I enjoy my "GP Days"- the medicine, the patient interactions and the different pace to hospital medicine but am glad to be a salaried doctor dealing with only one employer. Working for Queensland Health has been helpful in accessing PDL, career progression and maternity leave. This would be complicated by working in a traditional private practice also.*
- *I have previously been working in a GP setting. Unfortunately, as a female, I have had some very unpleasant issues arising from the vulnerability of being the only person in the room with the patient. I do not appreciate the lack of protection for the GP. I do not feel this is a safe environment, particularly in a rural town where patients can find you out of hours.*

One comment addressed difficulties associated with managing practice and familial commitments:

I'm currently balancing parenthood with work and would find it difficult to manage on-call at the hospital with private GP Work and childcare.

Appendix 7: Online Survey Results

What is working well and what could be improved?

Responses from doctors working across both primary and secondary services: Free text comments

Doctors currently working across a general practice / AMS and a hospital work setting were asked to comment on what works well and what could be improved to foster collaboration and coordination. Free text comments arranged under commonly repeated topics are provided here.

Note: Bolding has been added.

Flexibility and rostering

- *Fixed and sequential days in each, no on-call prior to GP days. Understanding and **flexibility of the roster**. Needs both parties on-board.*
- *More **flexibility** of working in different settings will be good. And access to locums with help to improve work-life balance and helps to retain doctors to the regions.*
- *They are separate jobs. **Clear rosters** work.*
- *The lack of **engagement in Rosters** to assist in skill maintenance is disappointing, usually only called when it suits the Health Service in an emergency.*
- ***Work flexibility** in the practice & the hospital.*
- *Less on-call hours.*
- ***Rostering issues** require careful thought and imagination to balance the competing interests of individual doctors against the need for continuity of care in both hospital and GP settings.*
- *It works well having **flexible rostering**/contracts allowing me to work at both locations and avoid fatigue/on call when I am at the general practice I have much more access to professional development at the hospital, which makes it harder to attend courses that fall on my general practice days, I lose income doing this. Working in both a public and private system is complex, having two employers/contracts etc.*
- ***Collaboration on the roster.***
- *Shared responsibility, respectful colleagues and knowing each other. **Rostering more in advance** to allow for general practice coverage more easily. Shared registrars foster collegiality.*
- *Better support for VMO credentialing, maintenance of professional standards, **rosters** and integration.*
- ***Better collaboration with rostering.***
- ***Flexible employment** opportunities. Sharing of information.*

Shared patient information

- *Pick up the telephone when discharging patients or referring on for care in other setting. **Discharge summaries** are often **lacking in relevant information** and arrive later than attendance of patient. Collaborative meeting between hospital AMs and GP would be useful.*
- ***Shared patient electronic files.** Teams where every member works in both hospital and GP setting provides broader context and accountability/community engagement.*
- *We have a GP clinic we run in [XX location] 1 day a week. This is **paper based**, with no GP software program. There is no recall system, GP cycles of care or integrated Medicare billing. The **GP clinic does not link in with the hospital system** so unable to communicate directly.*
- *Easier access to patient information / data between the two settings. Availability of access to hospital data while at GP (e.g. **use of portable computer** or improved access to ieMR/The Viewer software).*
- *There is a good communication between the hospital and general practice through correspondence. The **timing for completion of discharge summaries could be improved** upon.*
- ***Combine electronic records.***
- *Improved discharge summary production GP access to ieMR Hospital access to GP records integrated education **shared appointments.***
- *Flexible employment opportunities. **Sharing of information.***

Single employer model

- ***Single employer** works well to allow for recruitment of sufficient doctors to meet primary care needs during hours and on call burden after hours.*
- *Works well: **integrated team** who all work for Queensland Health. No problems with billings/altered conditions.*
- *Could be improved: better fatigue and HR management (often when big night at hospital patients need to be cancelled next day or doctor works fatigued).*
- *Good Question. There are places where Rural Generalists work in both hospital and GP settings in a single employer model (such as the RFDS, and some parts of Queensland Health). I think improvements could be made to entrench rural generalist practice in state-wide clinical governance and credentialing to ensure that rural doctors are not pushed out of procedural roles, particularly in larger rural communities, by metro subspecialists. Focus on a **single employer** to assist with coordination of leave and other arrangements would be useful. In addition, a **focus on the "soft" aspects of work**, rather than remuneration is needed (e.g. supporting permanent FIFO and other arrangements for continuity and ending the obsession with having to live in a community to contribute to it).*

